Student Manual
Equine Specialist in Mental Health and Learning Workshop
This manual is intended for use by persons interested in gaining more knowledge about becoming a riding instructor for persons with disabilities. It is expected that the procedures or practices described in this manual will be carried out by trained and qualified evaluators, according to the recognized standards and established guidelines of PATH Intl. and in the field of therapeutic riding. No warranty, expressed or implied, is made regarding the content of this manual by its authors, editors, reviewers, contributors or sponsors.

I thought this book needed this page so I pulled it from another one we did. This paragraph is not correct for this book, it needs to be re-written.
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Schedule

Day 1: 8am-5pm
- Welcome
- About PATH Intl.
- The Team
- HIPAA and Confidentiality
  
  **LUNCH**
  - Relationship Exercise
  - Equine Behavior and Management
  - Death of a Program Animal
  - Abuse of Animals and Aggression
  - Closing

Day 2: 8am-5pm
- Partner vs. Tool
- Riding Lesson vs. Meeting Therapy Goal or Education Plan
- Equine Behavior and Ethical Treatment of Equines
- Ethical Parameters
  
  **LUNCH**
  - Design Lesson Plans
  - Group Work
  - Reporting and Discussion

Day 3: 8am-5pm
- Define Partnership
- Collaboration Exercise
  
  **LUNCH**
  - Role Play
  - Processing and Final Reflection
Introduction

What you should expect to learn in this workshop:

To be able to:
- Create a therapeutic environment
- Understand equine care and management and ethical treatment of the EFMHL equine
- Understand how to maintain PATH Intl. ethics and standards including the ethical treatment of the equine
- Design appropriate exercises that should be based on the IEP or mental health treatment plan
- Collaborate with the other members of the team (Mental Health Professional, Volunteers, Equine) to meet treatment goals or the individual education plan

Beginners Mind:

The richness of the present-moment experience is the richness of life itself. Too often, we let our thinking and our beliefs about what we “know” prevent us from seeing things as they really are. We tend to take the ordinary for granted and fail to grasp the extraordinariness of the ordinary. To see the richness of the present moment we need to cultivate what has been called “beginners mind”, a mind that is willing to see everything as if for the first time.

…An open, “beginner’s mind” allows us to be receptive to new possibilities and prevents us from getting stuck in the rut of our own expertise, which often thinks it knows more then it does. No moment is the same as any other. Each is unique and contains possibilities. Beginner’s mind reminds us of this simple truth.

This passage is taken form: Full Catastrophic Living, “Using the wisdom of your body and mind to face stress, pain, and illness.” By Jon Kabat-Zinn, Ph.D.
What is PATH Intl.?

What does PATH Intl. do?

Why is it important for PATH Intl. to have industry standards?
PATH Intl. Mission:
PATH Intl. changes and enriches lives by promoting excellence in equine-assisted activities and therapies.

PATH Intl. Vision:
PATH Intl. is the global authority, resource and advocate for equine assisted activities and therapies and the equines in this work that inspire and enrich the human spirit.

Core Values:
Access and inclusion – promoting diversity and opportunity in equine-assisted activities and therapies.

Compassion and caring – providing a culture of safety, understanding and ethical treatment of humans and horses engaged in equine-assisted activities and therapies.

Cooperation and collaboration – connecting and partnering with those who share the PATH Intl. vision in a mutually beneficial manner.

Education – sharing valued knowledge with our constituents to facilitate their success.

Excellence – promoting quality in all undertakings.

Innovation – encouraging and supporting creativity, inquiry, and cutting-edge research.

Integrity and accountability – ensuring that all business is based on ethical principles and conducted with transparency.

Professionalism – enhancing the value and credibility of the industry.

Service – providing effective and responsive information and programs to our constituents.

Holistic – promoting an awareness of body, mind, and spirit in equine-assisted activities and therapies.
PATH Intl. Code of Ethics
Approved by PATH Intl. Board of Trustees October 21, 2010

Preamble
PATH Intl.’s Code of Ethics sets forth ethical principles for all PATH Intl. members which includes individuals and centers and is binding on all staff. Centers are obligated to insure that all staff, professionals, and volunteers comply with this code. While each of the following codes will apply to all members, the applicability of each code may be determined by the role of the member and the setting.

The practice and preservation of the highest standards of ethical principles and integrity are vital for the responsible implementation of obligations, activities and services provided by PATH Intl. members and centers. All members and centers are responsible for maintaining and promoting these ethical practices. The PATH Intl. Code of Ethics is intended to be used as a guide for promoting and maintaining the highest standards of ethical practice, personal behavior and professional integrity.

The guidelines expressed in the code are not to be considered all-inclusive of situations that could evolve under a specific principle, nor is the failure to specify any particular responsibility or practice a denial of the existence of such responsibilities or practices. The guidelines are specific statements of minimally acceptable conduct or of prohibitions applicable to all members and centers. PATH Intl.’s Code of Ethics is designed to be appended to such other codes as may be applicable (such as: medicine, psychology, nursing, social work, etc.).

In recognition of the responsibility inherent in the delivery of services provided by equine-assisted activities and therapies, PATH Intl. asks all members and center personnel to subscribe to the following to the extent permitted by law:

Principle 1
The member respects the rights, dignity and well-being of all individuals (human and equine) and promotes well-being for all involved.

Guidelines:
1.1 The member shall promote a holistic awareness of body, mind, and spirit in equine activities and therapies for all involved.

1.2 The member shall be responsive to, and mutually supportive of, the individuals served including families, colleagues and associates.

1.3 The member shall respect the unique nature of each individual and shall be tolerant of, and responsive to, differences. The member shall not discriminate based on age, gender, race, nationality, religion, ethnicity, social or economic status, sexual orientation, health condition or disability.

1.4 The member shall follow equal employment opportunity practices in hiring, assigning, promoting, discharging and compensating staff.

1.5 The member shall maintain in professional confidence participant, volunteer, and staff information, observations or evaluations and shall adhere to all legal requirements.

1.6 The member, in community settings, shall use caution in forming dual or multiple relationships with participants or former participants where there is a risk of a conflict of interest. The member, in clinical treatment settings, shall avoid dual relationships when possible. In situations where dual relationships are unavoidable, the member shall be responsible for setting clear, appropriate and sensitive boundaries.

1.7 The member will understand the sensitive nature of physical touch and use it with caution.
**Principle 2**
The member accepts responsibility for the exercise of sound judgment and professional competence.

Guidelines:
2.1 The member shall accurately represent his/her level of expertise, experience, education and actual practice and provide service only to those individuals he/she can competently serve.

2.2 The member shall engage in sound business, employment and administrative practices.

2.4 The member shall engage in continued personal growth, continuing relevant education and professional skill development.

2.5 The member shall recognize and take appropriate action to remedy personal problems and limitations that might cause harm to recipients of service, colleagues or others.

2.6 The member shall demonstrate objectivity and fairness by interacting with individuals in an impartial manner.

2.7 The member shall accept responsibility for the exercise of sound judgement when interacting with individuals and animals.

2.8 The member shall demonstrate openness to, and respect for, other colleagues and professionals.

**Principle 3**
The member shall respect the integrity and well-being of program equines and animals whether owned, leased or borrowed.

Guidelines:
3.1 The member shall recognize and respect the individual character, nature, and physical attributes of each program equine.

3.2 The member shall encourage safe and respectful human and equine interactions, placing equines in activities suited to their temperament and physical ability.

3.3 The member shall support the highest standard of care, maintenance and selection for each program equine, understanding and responding to the equine’s need for socialization, play, turnout, time off and retirement.

3.4 When equines are borrowed or leased, the same high standards of equine respect, care and maintenance apply.

3.5 The member shall cultivate a barn and practice environment that supports personal and professional development and is compliant with PATH Intl. standards.

**Principle 4**
The member shall be truthful and fair in representing him or herself and other members or centers.

Guidelines:
4.1 The member shall be responsible for providing each participant with accurate information regarding programs, services, professional training and credentials, as well as possible benefits, outcomes, expected activities, risks and limitations of the service or program.

4.2 The member shall meet commitments to participants, colleagues, equines, agencies, the equine-
assisted activities and therapies community and the community at large.

4.3 The member shall use the PATH Intl. logo only in accordance with the PATH Intl. brand policy.

**Principle 5**

The member shall seek to expand his/her knowledge base related to the field of equine-assisted activities and therapies.

Guidelines:

5.1 The member shall maintain a high level of professional competence by continued participation in educational activities that enhance basic knowledge and provide new knowledge.

5.2 The member shall support the sharing and dissemination of information, the provision of training and conducting of research for the benefit of the profession.

5.3 The member shall demonstrate commitment to quality assurance. The member in clinical treatment settings shall engage in providing and receiving individual or peer supervision and/or staffing consultation on a regular basis.

**Principle 6**

The member shall honor all financial commitments to participants, personnel, vendors, donors, PATH Intl. and others.

Guidelines:

6.1 The member shall negotiate and clarify the fee structure and payment policy prior to the initiation of service and charge in a responsible and reasonable manner.

6.2 The member shall not misrepresent in any fashion services rendered or products dispensed.

6.3 The member shall be truthful and fair in representing itself in fundraising activities.

6.4 The member shall honor all debt obligations.

6.5 The member shall maintain membership in PATH Intl. and pay the appropriate fee as determined by the Board of Trustees. Instructors shall remain in good standing with the annual compliance process for instructors.

**Principle 7**

The member shall abide by PATH Intl. Standards and Guidelines and all state, local and federal laws.

**Principle 8**

The member supports PATH Intl. in its efforts to protect participants, equines, the public and the profession from unethical, incompetent or illegal practice.

Guidelines:

8.1 The member shall present this PATH Intl. Code of Ethics to all staff and personnel, outlining their collective obligation to support it and address any questions or concerns pertaining to it.

8.2 The member accepts the responsibility to discuss suspect unethical behavior directly with the parties involved and, if unresolved, to report unethical, incompetent or illegal acts to PATH Intl.
PATH Intl. Precautions & Contraindications
Which relate to mental health and learning.

Medication
Consideration should be given to the medications, prescription and over the counter, which the participant is taking. Listed below are general categories of medications common for the participant in PATH Intl. programs. Be certain to be familiar with all of the medications. Take note of when the medications are taken (i.e., directly before a session or several hours prior), or recent changes in medications. Medications may have side effects, and some medications can become toxic if the dosage is not controlled. Some medications are affected by environmental factors such as sunlight. Medication interactions can be toxic. For example, erythromycin may cause acute elevations of the commonly used anti-convulsant carbamazepine (Tegretol). Fact sheets about specific medications are available at all pharmacies. Once you have read these, if there are additional questions regarding medications, call the pharmacist or physician.

Special Considerations:

- **Phototoxicity:**
  Some drugs become toxic when chemically activated in the skin by light (ultraviolet or visible radiation). Examples of phototoxic drugs include antibiotics such as tetracyclines (commonly used to treat severe acne), sulfonamides, and chlorpromazine (Thorazine). Control exposure to the sun by using protective clothing or sunscreen for participants taking these medications.

- **Photoallergy:**
  Some drugs are activated to a more potent allergen in the skin upon exposure to light (ultraviolet or visible radiation). Clinically, a photoallergy may manifest as reddened skin (that resembles sunburn) or as hives, which may appear a few minutes after exposure to sunlight. Drugs capable of causing a photo allergic reaction include phenothiazines, sulfonamides, hexacholoraphene, and topical antihistamines.

- **Allergy Control:**
  An antigen-antibody reaction stimulating the release of histamine produces the most common symptoms associated with allergy; stuffy nose, runny nose, hives and itching, and watery, itchy eyes. Many antihistamines, or allergy control medications, are available without a prescription. These medications may be sold alone or in combination with other drugs.

**Precaution:**
Sedation and dizziness are common side effects of antihistamines. Confusion may be seen in the elderly and hyper-excitability in children because of the effects of antihistamines on the central nervous system. There are several non-sedating antihistamines, but they are generally prescribed for older children and adults.

- **Antibiotics:**
  These medications are used to kill or inhibit the growth of susceptible bacteria. They are not active against viruses or fungi. Antibiotics are subdivided into categories depending on chemical similarities and antimicrobial spectrum.

**Precaution:**
Many antibiotics cause gastrointestinal upset, nausea, and diarrhea that may cause discomfort. Photosensitivity is common to certain antibiotics such as the tetracyclines, sulfonamides and quinolones/Cipro. Protective clothing and sunscreens are recommended.

Significant reactions to antibiotics may occur such as coma, seizures, anaphylaxis, shortness of breath, and hives. Penicillin and sulfa drugs can cause life threatening allergic reactions.
- **Anti-Convulsants:**
  These medications include a variety of agents, all capable of depressing abnormal neuronal discharge in the central nervous system that may result in seizures. They are also used in the treatment of psychiatric behavior disorders particularly mood disorders, aggression, and impulse control disorders.

  **Precaution:**
  Drowsiness, incoordination, vertigo, nystagmus (abnormal eye movement), mild nausea, are common side effects especially when these drugs are just started or if the dose has been increased too quickly.

  Double vision is a common side effect of carbamazepine (Tegretol) and often goes away spontaneously or after the dose is decreased. Aggression, increased irritability, mood lability, tantrums, hyperactivity, and paradoxical behavioral rebound may all be side effects of these medications. These side effects often resemble the target symptoms they are meant to treat. Close monitoring and communications with the participant’s physician or therapist is essential to determine if the drug is helping or hindering therapy.

  Caution participants to use sunscreen and protective clothing to prevent photosensitivity reactions. Participants taking valproic acid might bleed more easily upon bumps or cuts to the skin.

- **Anti-Depressants:**
  These medications are used in the treatment of various forms of depression often in conjunction with psychotherapy. Other uses include the treatment of anxiety, enuresis (bedwetting), insomnia, obsessive-compulsive disorder, and chronic pain syndromes.

  **Precaution:**
  Dizziness or drowsiness may occur. Rapid position changes may cause a drop in blood pressure with lightheadedness or weakness. Participants may experience dry mouth or difficulty voiding. Participants who have seizure disorders may be likely to have more seizures. Symptoms of toxicity and overdose of anti-depressants include chest pain, severe headache, neck stiffness, nausea, vomiting, photosensitivity and enlarged pupils.

  Monoamine Oxidase Inhibitor (MAOI) is a type of anti-depressant that requires strict dietary restrictions. Tyramine, a substance found in aged food such as sauerkraut, pickles, raisins, ripe bananas, cheese, etc., can combine with the MAOI to cause high blood pressure. If symptoms of high blood pressure occur (nausea, sweating, neck stiffness, and sudden headache) activity should be restricted until the situation is assessed.

- **Anti-Spasmodics**
  Excessive uncontrolled muscle activity (tension, stiffness, tremors, writhing) is common for many disorders involving the nervous system, including Cerebral Palsy, Brain Injury, Stroke and Multiple Sclerosis. Medications such as Baclofen, Dantrium, and Valium work centrally to lower muscle activation. Medication is most often taken orally; occasionally it is administered by an implanted pump. (See Equipment). Botox injections are used to inhibit muscle activation locally, in the area of the injection, and generally last 8-12 weeks.

  **Precaution:**
  Initially, or in elevated doses, there may be fatigue or weakness. These effects often diminish as the individual accommodates to the medication and as the dosage becomes regulated.

- **Attention Enhancers**
  These medications are used as an adjunctive treatment in the management of attention deficit hyperactivity disorder (ADHD) and in the treatment of narcolepsy.
Precaution: Stimulant medication can worsen pre-existing motor tics or result in new tics including those observed in Tourette’s Syndrome. The participant’s caregiver or physician should be immediately notified if tics are observed. Recognize that stimulant medication is very short lived so that dosing time may significantly impact on a participant’s ability to focus attention during the riding session. Participants who are on sustained-release methylphenidate (Ritalin) may demonstrate day to day variability in their target symptoms.

Be aware that if medication is administered at a therapeutic riding center, when sustained release methylphenidate is chewed instead of swallowed, very high blood levels can result with toxic side effects. If stimulants are taken in large quantities, the following signs and symptoms may result: dry mouth, dilated pupils, rapid heart rate, increased blood pressure, stereotyped behavior, irritability, or paranoia.

**Blood Pressure Control**

Because so many different body systems are involved in the maintenance of normal blood pressure, there are several classifications of drugs used to reduce high blood pressure. If a single drug is not effective, commonly a second or even a third anti-hypertensive drug, with a mechanism of action different from the others is added to the participant’s drug regimen. These medications CONTROL, but do not, CURE high blood pressure.

Precaution: Drowsiness, sedation, and fatigue may occur which might make a participant more susceptible to an injury and less responsive in an emergency situation. Orthostatic hypotension (low blood pressure) may occur, so make position changes on the equine slowly. Riding in hot weather may enhance blood pressure lowering effects. Dry mouth, constipation, and rapid heart rate occur with some drugs. Make sure the participant’s caregiver or physician is notified if concerns arise. Be aware that abrupt withdrawal of medication may cause rebound hypertension (blood pressure increases).

**Blood Thinners**

Blood thinning medication such as aspirin or Coumadin may be prescribed for those who are at risk for blood clots, which may cause stroke or heart problems. Clotting time of the blood should be monitored to determine if the appropriate amount of medication is being prescribed.

Precaution: Any fall, kick or bump is a potential problem for participants on this medication. Bleeding or bruising is more significant because of the decreased clotting speed of the blood. Of greater concern would be the potential for internal bleeding following an injury that cannot be easily observed. Extreme caution should be taken with these participants.

**Contraindication:**

Excessive bruising, blood in the stool, blood-clotting levels not periodically monitored by the physician are all contraindications. Poor accessibility to emergency medical care is also a contraindication, particularly with these participants.
**Bronchodilators**
These medications are used in the treatment of reversible airway obstruction (reactive airway disease) due to asthma or chronic obstructive pulmonary disease. Bronchospasm which results in a narrowing of the airway may be triggered by respiratory irritants such as pollens, molds, dust, animal dander, feathers, dust mites, cockroaches, emotional factors, exercise, or infection. If possible, a participant on a bronchodilator should identify his/her most common stimuli. For example, a windy day or dry conditions might create excessive dust. Grooming may not be tolerated by some because of dust and dander. Hay and grain storage areas that tend to harbor mold or other barn animals such as cats might trigger an attack among very susceptible individuals. Bronchodilators are often administered via metered dose inhalers (MDI’s) either with or without a spacing device. Sometimes the medication is prescribed prior to an activity or exposure to prevent bronchospasm from occurring in the first place. How medication is to be administered (by mouth, via a small compressor, or via a MDI with or without a spacer), when medication is to be administered (before the activity or as needed (PRN) for symptoms), and how frequently the medication can be repeated should be identified.

**Precaution:**
Side effects of these medications can include rapid pulse, dizziness, blood pressure changes and may produce paradoxical or reverse symptoms and death.

**Mood Stabilizers**
Lithium is a medication used to stabilize abnormal highs and lows of mood swings. The person on lithium should have regular blood testing performed to ensure that the lithium in the bloodstream is in a therapeutic range. Too low a level is ineffective, and too high a level can result in the serious problem of lithium toxicity. Caution should be taken with potential drug interaction, especially with non-steroidal anti-inflammatory medications (NSAIDs) which can be purchased over the counter.

**Precaution:**
Symptoms of lithium toxicity are broad. They may include nausea, vomiting, diarrhea, tremors, increased or decreased thirst, slurred speech, lethargy, confusion, and dizziness, headache and eye pain. Pay special attention to the participant’s fluid intake, particularly on hot days, as fluid loss from sweating without adequate replacement can result in increased concentration of lithium in the blood stream. Coffee, tea and caffeinated sodas are not appropriate as they act as diuretics and will enhance fluid loss. A participant whose lithium level is being adjusted needs to be monitored very closely during the process. If symptoms warrant, program modification may need to be considered until drug stabilization has occurred.

**Pain Control**
Analgesia is the term used for pain relief. Many medications used to control mild to moderate pain also reduce fever and have anti-inflammatory effects. They are useful in many acute and chronic conditions. Acetaminophen (Tylenol) has no anti-inflammatory effects, so it is used only to reduce pain and fever. Consider the source and type of pain when determining if someone in pain should be riding. Pain medications are used to control the sensation of pain, and this may assist a participant to participate in an activity without being distracted by pain. Of concern is that the medication may mask pain that which could cause an unsafe situation leading to further tissue damage.

**Precaution:**
Pain medications may cause drowsiness, altered mental function, and/or balance impairment. Large doses of salicylates (aspirin) may cause ringing in the ears or hearing loss that may also affect the participant’s balance. Nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen, naproxen, indomethacin, and piroxican may cause gastrointestinal (GI) irritation such as nausea, vomiting, diarrhea, gas and even GI bleeding. Be aware of the particular side affects associated with the medications being used.
Contraindication:
If pain persists while riding, especially when pain medications are used. If the origin of the pain will worsen with riding, or if the risk of undetected injury is greater than the benefit of riding, than riding for the individual in pain is contraindicated. Salicylates (aspirin) should not be used in persons under the age of 21 because of the risk of Reye's Syndrome, a potentially fatal disease involving brain and liver dysfunction.

- **Steroids (Glucocorticoids)**
  Steroids produce profound and varied metabolic effects in addition to modifying the normal immune response and suppressing inflammation. Long-standing use is most often associated with chronic conditions.

Precaution:
Steroid drugs are immunosuppressant and may mask symptoms of infection. These participants should avoid people with known contagious illnesses. Be aware that steroids may cause psychosis or depression and the reason for this is not certain. Skin changes may be seen and can include tiny bruises, red/purple stretch marks and thinning of the skin. This may make a participant more susceptible to pressure areas or tears of the skin with friction. (See Skin Breakdown). Long-term use will lead to osteoporosis and these participants will be at greater risk of bone fractures. (See Osteoporosis, Pathologic Fractures).
Equine Facilitated Psychotherapy Standards
(From the 2010 PATH Intl. standards manual)

**EFP1 MANDATORY**

Is there written evidence that the mental health professional who provides direct treatment services meets the following qualifications:

1. Is credentialed (licensed, certified, etc.) as a mental health professional that has met the criteria to legally and independently provide psychotherapy and/or mental health counseling in the state (or country) in which the services are being delivered?
2. Maintains current professional liability insurance?
3. Is a PATH Intl. Certified Instructor or is assisted by a PATH Intl. Certified Instructor when conducting EFP sessions?

   Yes    No

*Interpretation*: Legal requirements for the practice of psychotherapy and/or mental health counseling vary from state to state in the United States. It is the responsibility of the center to provide the necessary documentation of the ability to independently provide services in order to comply with their state and country laws and this standard.

*Compliance Demonstration*: Visitor observation of WRITTEN legal licenses/certifications, insurance documents, and visitor observation of EFP session.

**EFP2**

Is there a written contractual agreement between the mental health professional and the center?

   Yes    No

*Interpretation*: The mental health professional, whether a paid employee, a contractor, or an unpaid provider, should have a written agreement that clearly delineates the relationship between the provider and the center. The contract may include performance expectations; compensation; who is responsible for professional and general liability coverage; length of employment, contract, or donation of services; tax responsibilities; termination guidelines (such as “at will”); reference to job description and other personnel policies.

*Compliance Demonstration*: Visitor observation of WRITTEN contracts.

**EFP3**

Is there a written consent for evaluation and treatment specific to psychotherapy available on site for each client?

   Yes    No

*Interpretation*: The legal and ethical practice of psychotherapy/counseling requires formal, written agreements between the client (or the legal guardian) and the therapist prior to treatment being initiated.

*Compliance Demonstration*: Visitor observation of randomly selected WRITTEN documents.
EFP4

Is there a written procedure in practice for release of information specific to psychotherapy and/or mental health counseling, to an outside source concerning a client receiving equine facilitated psychotherapy and/or mental health counseling?

Yes  No

Interpretation: The mental health professional providing treatment to a client in equine facilitated psychotherapy or mental health counseling may receive requests from outside sources requesting release of information. This information is considered confidential and must be treated as such. The mental health professional and the center need to have a procedure both written and in practice for dealing with such requests as well as a form (these forms should be HIPPA compliant) to facilitate the request. Such outside sources could include probation officers, other therapists, or child and family caseworkers.

Compliance Demonstration: Center explanation of procedure; visitor observation of randomly selected WRITTEN release forms.

*EFP5 MANDATORY

Is there a procedure in practice which requires written documentation for personnel and volunteers to be:

1. Assessed for ability to work with particular clients or client populations?
2. Consistently involved?
3. Oriented to the equine facilitated psychotherapy program?
4. Oriented to the needs of the specific clients with whom they assist?
5. Involved in a post-session processing with the mental health professional, PATH Intl. Certified Instructor, and other pertinent people?

Yes  No

Interpretation: The practice of EFP may necessitate the inclusion of specially screened and trained volunteers or personnel. Because of the nature of EFP programs, it is necessary for the volunteers or personnel to be thoroughly knowledgeable and experienced to provide the standard of service required in an EFP program. This includes a maturity level that must be assessed for appropriate behavior and conduct during EFP sessions. To obtain and maintain this standard, personnel, and volunteers must receive additional and ongoing training. They should be thoroughly oriented to the program’s philosophy, mission/vision statements, intake criteria, cancellation policies, administrative structure/lines of communication, and other related program components.

EFP assistants should also receive very specific information related to client-centered issues, such as client behaviors, treatment plans, and confidentiality policies. (Examples: treatment goals, behavioral modification programs, early signs of behavioral escalation, medication side effects, appropriate personal boundaries - physical, emotional, social). Consistency and commitment from the EFP assistants is necessary in order to provide stability of treatment to the clients. Post-session processing enables the team to review the session in order to address issues, concerns, and plan for the future.

Compliance Demonstration: Visitor observation and interview; observation of randomly selected WRITTEN documents.
EFP6

Is there a procedure in practice to assess and address the supervision and consultation needs of the PATH Intl. Certified Instructor, the mental health professional, and the EFP assistants?

   Yes   No

*Interpretation:* Clinical supervision provides all those involved with the treatment process an opportunity to share, explore, and address issues related to counter transference (e.g. personal feelings that arise during client contact) as well as to process issues related to treatment provision (e.g. problem solving to modify a treatment approach and to consistently implement the plan). The amount of supervision is left to the center and the professional after the procedure to assess and address the clinical need for such supervision has been carried out.

*Compliance Demonstration:* Personnel description of procedure.

*EFP7 MANDATORY*

Does the facility include a private area suitable for conducting a confidential interview or processing session with an equine facilitated psychotherapy or mental health client?

   Yes   No

*Interpretation:* In the circumstance in which a client is unable/unwilling to participate in equine activities; is decompensating psychiatrically or behaviorally, or just needs a confidential place to process or share feelings, it is essential that the therapist and client have a space in which to meet. The space does not have to be an office but should offer a place to sit down and have a private conversation.

*Compliance Demonstration:* Visitor observation of the area that is used for interviewing/processing.

EFP8

Is there evidence of written documentation available at each activity site for each client:

1. A comprehensive intake assessment?
2. A treatment plan which includes specific psychotherapy/mental health counseling goals?
3. Periodic review?
4. Ongoing client progress notes?

   Yes   No

*Interpretation:* Typically, a primary mental health professional's documentation includes a comprehensive mental health assessment including chief complaint, psychosocial history, alcohol and drug history, symptom assessment, and diagnostics. The treatment plan specifies the needs of the client, goals of treatment, therapeutic modality, and time frames for achievement. The treatment goals and plans should indicate that reviews and updates are occurring on an ongoing basis. The file should indicate that a screening for possible behavioral/psychiatric precautions/contraindications was done initially and is addressed on an ongoing basis as needed. Ongoing progress should be noted each visit. However, some mental health professionals see clients as an adjunct treatment and will have access to the above information through the primary therapist/agency. If this is the case, a signed release of information should be present in the client's file, and there should be evidence of periodic liaison with the primary therapist. The licensed/credentialed mental health treatment provider documents the client's status, therapeutic interventions employed, and client's responses to the intervention, while the PATH Intl. Certified Instructor documents the equine's status, responses, and horsemanship skills addressed in the session. (Both of these responsibilities may be addressed by the same person, if that person is dually trained).
Compliance Demonstration: Visitor observation of WRITTEN documentation in randomly selected client files of each therapist providing equine facilitated psychotherapy.

**EFP9**

DNA (does not apply): If the program does not conduct research efficacy studies.

**Does the program have a written procedure in practice for conducting research efficacy studies involving the program’s participants, equines, personnel and volunteers?**

Yes  No  DNA

*Interpretation:* Programs involved in investigative studies are advised that they should comply with federally recognized standards and requirements for the conduct of research efficacy studies involving human and/or animal subjects.

*Compliance Demonstration:* Visitor observation of WRITTEN procedure and personnel explanation.
Specialty Forms

Please be advised that the following forms are provided as part of this manual as samples for format only. It is the responsibility of each center to know and understand the laws in your state that regulate the content, necessary components and intent of each of these documents.
Equine Facilitated Psychotherapy
Consent for Release of Confidential Information

I, _________________________________________________________ hereby authorize and request that

(client)
___________________________________________________________________________ may release to

(therapist)
______________________________________________________________________________________________

(therapeutic riding center)

the following information (please check the allowable information):

☐ Admission for treatment
☐ Psychiatric evaluation
☐ Psychosocial assessment
☐ Treatment progress notes
☐ Physician orders
☐ Diagnosis
☐ Psychological testing results
☐ Treatment plan
☐ Discharge summary
☐ Other _________________________________

The purpose of this disclosure is for the development of an Equine Facilitated Psychotherapeutic plan and
program. I understand that this authorization will remain in effect until _____________________ (specify date
which is not to exceed 12 months).

This information will be released in the following format (verbal per telephone, electronic, via mail, hand-
carried): ______________________________________________________________________

Pursuant to Federal Regulations, this information will not be forwarded to any other provider or agent.

______________________________________________________________  ____________________________
Client Date

______________________________________________________________  ____________________________
Parent or Legal Guardian Date

______________________________________________________________  ____________________________
Witness Date

______________________________________________________________  ____________________________
Referring Therapist Date

______________________________________________________________
Address of Therapist
Mental Health Data Form

Client's Name: ____________________________________________

Age: _______ DOB: ________________ Sex: _______ Height: ________________ Weight: ________________

Parent/Legal Guardian: __________________________ Phone: H _________________ W __________________

Address: ______________________________________________________________________________________

Physician: __________________________________________________ Phone: ____________________________

Therapist: __________________________________________________ Phone: ____________________________

Diagnosis (DSM-IV)

Axis I: ______________________________________________________________________________________

Axis II: ______________________________________________________________________________________

Axis III: ______________________________________________________________________________________

Axis IV: ______________________________________________________________________________________

Axis V: ______________________________________________________________________________________

Presenting Problems

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

Current Medications

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Route</th>
<th>Time</th>
<th>Purpose</th>
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<tbody>
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Psychiatric Treatment History

Current Therapy ______________________________________________________

Outpatient ______________________________________________________

Inpatient Therapy ______________________________________________________
Therapeutic and Safety Issues

Check and describe applicable issues (indicate current or history of):

- inattention
- hyperactivity
- lack of concentration
- learning disabilities
- developmentally delayed
- mentally challenged
- boundary issues
- social skills problems
- problem with peers
- separation anxiety
- anxiety
- phobias
- aggressive
- assaultive
- manipulative
- unpredictable or dangerous behavior
- sensory impairment
- sensitivity, preferences
- tics or stereotypic behavior
- psychosomatic symptoms
- medical issues
- self-injurious behavior
- suicidal ideations
- history of runaway
- issues of parental support
- issues of family support
- sexual abuse/acting out
- history of physical
- emotional abuse
- hallucinations
- delusions
- illusions
- dissociations
- substance abuse problems
- legal problems
- school problems
- history of animal abuse and/or
  - fire setting
- seizure disorder
- possible medication side effects

________________________________________________________________________

Information Source                                      Date Form Completed

Ideally this form is designed to be used in conjunction with the PATH Intl. Rider’s Medical History,
Physicians Statement and Physicians Release Statement.
Equine Facilitated Psychotherapy Referral Form

Client’s Name: _____________________________________________ DOB: ___________________ Age: ______
Address: ___________________________________________________ Phone: ________________________
Diagnosis: _____________________________________________________________________________________
Recommended Frequency and Duration of Sessions: ________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
Type of Format: ______ Group Work  ______ Individual Work  ______ Family Work
Specific issues to address:

Current treatment goals:

Additional information:

______________________________________________________________  ____________________________
Health Care Professional                                  Date

____________________________________________________   ______________________________________
State Credentials/License #                                 Phone & Fax Numbers

___________________________                        __________________________
Address

Return to: (riding program’s name & address)

Thank You for Your Participation and Referral
CONSENT FOR TREATMENT AND RELEASE OF LIABILITY

Therapist Name or Business Name

Address and Phone Number

*This is not a complete form and may not be photocopied. Each provider of therapy services must create their own form after obtaining legal counsel in order to include appropriate wording and content for particular state regulation and different treatment situations.

Samples of wording that may be included:

“No child can be accepted for hippotherapy until all forms have been completed by the parent/guardian. If the patient is of legal age and mentally competent, he/she may complete the forms without parent’s or guardian’s signature”

“Although every effort will be made to avoid accident or injury, NO LIABILITY can be accepted by any of the organizations concerned including (name of center or therapy practice/provider), its officers, trustees, agents, employees, each and every and every one of its members and associates, the property owners upon whose land the hippotherapy sessions are conducted.”

“I request and consent to treatment that may include hippotherapy, and I have discussed this with my (my child’s) doctor. I understand that no liability can be accepted by any of the organizations concerned with this therapy, including (name of center or therapy practice/provider).”

Dated signatures of parent/guardian or patient of legal age must be included.
Psychosocial Safety Guidelines

Psychosocial Guidelines for providing Equine Assisted Activities and Therapies are offered as minimal parameters for safety. They are intended to heighten awareness in staff and center program personnel to psychosocial issues.

In these guidelines, “psychosocial issue” refers to any significant variation in cognition, mood, judgment, insight, anxiety level, perception, social skills, communication, behavior, or learning that has the potential to effect the participant’s safe participation in equine facilitated health and education services.

Examples of significant psychosocial issues may include and are not limited to anxiety disorders, psychotic disorders, mood disorders, behavioral difficulties and/or major life changes; environmental trauma (earthquake, fire, flood, hurricane), divorce, grief and loss, etc.

**PSG1.** Create a written policy of eligibility and continued eligibility requirements for participants with significant psychosocial issues.

**EXAMPLE:** The PATH Intl. Precautions and Contraindications information is a good resource to develop this policy. High-risk and/or historically unstable clients should receive ongoing assessment to determine safe participation. A participant’s condition may change at any time and necessitate reevaluation of ongoing eligibility.

Variables to consider may include the mission statement of the operating center, experience and expertise of the instructor, suitable equines; height and weight limits of equines; availability and training of volunteers; and access to mental health professionals.

**SUGGESTIONS:** Practical means of accomplishing ongoing assessment include:

a. “Checking-in” at the beginning of each session with someone knowledgeable about the participant’s recent behavior and events in their lives: “How has.........................been doing? Have there been any major changes in behavior or any major life change events?” or “How have you been? Is there anything I need to know in order for us to work together safely today?”

b. Asking periodically if the participant has been compliant with treatment, medications, and successful in school or not.

c. Regular communication with any agency sending or referring participants to the program and/or the participant’s psychotherapist, teacher, etc. This may include topics such as screening procedures, safety concerns, staffing needs, IEP goals, etc.

d. Administrative review of current eligibility policy.

e. Explanation of eligibility policy on promotional materials such as brochures and website.

**PSG2.** Utilize an appropriately credentialed mental health professional for consultation and training purposes.

**EXAMPLE:** Serving participants with psychosocial issues requires center staff to be able to understand mental health terms, be able to communicate with other professionals and families regarding mental health issues, be able to understand basic legal guidelines concerning treatment and emergency care, be able to assess accurately and address needs for staff and volunteer training, and be able to address issues related to risk management and environmental safety.

**SUGGESTIONS:** The mental health professional may be on staff at the center, secured as consultant to the center staff, affiliated with an agency requesting services, or otherwise available and accessible to the center (e.g. on the center’s Advisory Council or Board of Directors).

**PSG3.** Screen for psychosocial issues.

**EXAMPLE:** It is impossible to discern the presence of these issues without asking the participant or guardian prior to accepting the client into the program, and as your program files are updated annually. While the
physician’s statement suggested by PATH Intl. also requests data regarding “psychological impairment”, this
may not be adequate, as there are numerous situations about which a primary health care provider would
have no such knowledge.

SUGGESTIONS: A question or brief series of questions regarding the presence of significant psychosocial
issues is added to the program’s application packet. Some mechanisms exist for requesting this information
directly from the participant and/or their legal guardian or representative. Examples of such questions
include:

a. Has the participant been diagnosed with any mental or behavioral health problem that may interfere
with safe participation in your center activities?
b. Does the participant have any special learning needs or receive special education services?
c. Has the participant experienced a major life change or trauma? How long ago? Is this an unresolved
issue?
d. Make use of documentation including assessments, flow sheets/progress notes and periodic parental/
professional consultations.

PSG4. In the event your screening process (3) reveals presence of significant psychosocial issues, it
is recommended that further information be gathered in consultation with the center’s mental health
professional.

EXAMPLE: Questions this consultation might address are:
1. What further information is needed?
   a. Is the prospective participant seeing another therapist?
   b. Is it important to seek the special education teacher’s suggestions?
   c. Is additional testing advisable?
   d. Does the diagnosis require further clarification?
2. What implications does this information have for the participant’s safe participation?
3. Who needs to know what? e.g.: What portions of the information does the instructor need? Volunteers?
   Administrators?
4. What is the process for data sharing in light of confidentiality?

SUGGESTIONS: It is recommended that a signed form be placed in the participant’s file containing a
statement from the participant or guardian that despite the presence of psychosocial issues (as elsewhere
noted), to the best of their knowledge they have no known condition which precludes their safe
participation in equine activities.

5. If serving client(s) with high risk for out-of-control behavior, have a plan to prevent and/or to intervene
in a mental health emergency.

EXAMPLE: Crisis prevention is much more effective than intervention and is accomplished by having an
adequate number of trained staff, good screening procedures, ongoing behavioral assessment, a good
knowledge of the participant’s past behaviors, and a physical environment that is made as safe and
supportive as possible.

This is similar to having adequate assistance for any participant who requires intensive staffing (e.g.
sidewalkers, extra mounting help, back riding, equine handlers) because of a physical disability or medical
condition.

Centers may need to consult with the participant’s therapist or the center’s therapist, as well as the
participant’s family and educators, to determine the need for this guideline’s implementation.

SUGGESTIONS: Centers will want to consider the need for both a general plan and participant’s specific
plans. It is preferable to have referring agency staff, not program volunteers or center staff, provide any
therapeutic holds or restraints.

28 | PATH INTERNATIONAL STUDENT MANUAL EQUINE SPECIALIST IN MENTAL HEALTH AND LEARNING WORKSHOP
Have an attorney review the wording of the Permission to Share Information Form and the Release to Seek Emergency Medical Treatment Form to ensure it provides maximum available protection under local laws. Legal forms and procedures for transport/emergency mental health evaluation differ from state to state.

Administrative review of selected center policies, application forms, behavioral health histories, permission forms, waivers, phone numbers and releases of information to contact the client’s primary mental health provider/agency as needed, and as applicable, legal forms for transport/emergency/mental health evaluation.

**PSG6.** Create a procedure for matching the participants to the following variables recognizing that each is a component of the therapeutic lesson design.

1. Equines
2. Tack
3. Equipment
4. Volunteers
5. Activity/experience
6. Group members/peers

**EXAMPLE:** In services with a mental health focus, it is often important to allow the participants as much input as possible while maintaining safe limits. It is the instructor’s responsibility to have a written lesson plan and to factor in additional variables, such as weather, equine needs/issues, volunteer/assistant availability, and clients’ fluctuating medical and behavioral/emotional status.

Care is given to avoid, recognize, and reassign potentially counter-therapeutic combinations of participants, volunteers, and equines.

**SUGGESTIONS:** Administrative observation of lessons/sessions and review of lesson plans and progress notes is recommended. Professional consultation regarding avoidance of counter-therapeutic combinations as listed above and for clinical supervision.

**PSG7.** Create a procedure to monitor and respond to each equine's level of stress. The importance of daily turnout cannot be over emphasized.

**EXAMPLE:** Even with the best stable management procedures, equines working in therapeutic programs are vulnerable to developing stress related symptoms/behaviors or “burnout”. Just as equines may develop physical problems when working with unbalanced riders, equines may develop behavior problems when they do not have the opportunity to release the stresses associated with working with participants with significant psychosocial issues, or being handled by multiple people, or by inconsistent handling techniques, etc.

Procedure may include daily observation and staff discussion of equines behaviors, stable management issues, written (turnout) policies, staff and volunteer training for safe process.

**SUGGESTIONS:** Daily turnout in a suitable area is recommended to foster most equines mental, physical, and emotional health. Equines that do not have this need addressed may develop physical, behavioral, and mental health concerns that affect program safety. Assess both the need for turnout as well as frequency, length, and nature of turnout.
EFP Precautions and Contraindications

EFP Precautions
Client has
- History of Animal Abuse
- History of fire setting
- Suspected current or past history of physical, sexual and/or emotional abuse
- History of seizure disorder
- Gross obesity
- Medication side effects
- Stress induced reactive airway disease (asthma)
- Migraines

Narrative for Precautions:
“Animal abuse” concerns are included in the interest of the horse’s welfare. If the horse is not safe, then the session cannot be safe.

“Fire Setting” histories should be carefully assessed to ensure the promotion of a safe physical environment.

“Active abuse” suspicions should always be reported to the appropriate authorities. Such reporting does not always result in cessation of the abuse. Clients are unlikely to be able to safely explore deep psychic issues in the context of a pervasively unsafe environment.

“Gross obesity” is associated with eating disorders and various other medical conditions. Obesity is a safety concern. Guidelines on weight limits for equines are included in the PATH Intl. Standards (for mounted activities).

“Medication side effects” can lead to severe alterations in balance, arousal level, coordination, and strength as well as difficulties with speaking and breathing. Programs develop and implement procedures and processes for remaining familiar with clients’ medication regimen and clients’ potential for and history of side effects.

An acute episode of “reactive airway disease” can be triggered by stress and anxiety, although all medical conditions have a psychosocial component. RAD is singled out because of its prevalence and potential for sudden, severe onset of symptoms.

If a “migraine” is in process, riding is not advised.
**EFP Contraindications**

Client is currently

- Actively dangerous to self or others (suicidal, homicidal, aggressive)
- Actively delirious, demented, dissociative, psychotic, severely confused (including severe delusion involving horses)
- Mentally unstable
- Actively substance abusing

**Narrative for Contraindications**

“Dangerous to self or others” is the clinically accepted term to describe those clients experiencing a psychiatric emergency. Equine experiences cannot be safely facilitated by clients exhibiting these behaviors.

“Actively delirious, demented, dissociative, psychotic, severely confused (including severe delusion involving horses)” and “actively substance abusing” reflects the committee’s agreement that equine experiences cannot be safely facilitated when clients are exhibiting serious alterations in mental status.

- “Mental instability” can be associated with a variety of psychosocial challenges. The committee seeks to enhance awareness that physical/medical issues must always be considered as part of a thorough clinical assessment.
**EFMHA**

**Equine Facilitated Mental Health Association History**

**EFMHA Vision Statement:**
A world in which the wisdom of equus moves us to develop and deepen our greatest potential.

**EFMHA Mission Statement:**
EFMHA’s purpose is to advance the field for individuals who partner with equines to promote human growth and development so that our members, clients and equines can succeed and flourish.

**EFMHA Beliefs:**
- Equines are sentient beings with feelings, thoughts, emotions, memories, and empathetic abilities.
- Equines can be active facilitators, evoking emotions in those who work with and around them.
- Equines function as partners in EFMH sessions and as such all sessions must be conducted to be mutually beneficial for all participants (includes equine).
- EFMHA believes that equines are NOT to be manipulated, scared or teased or used as a tool or props.

**EFMHA Integration with PATH Intl.:**
The Equine Facilitated Mental Health Association (EFMHA) was formed as a section of PATH Intl. in the spring of 1996. The mission of EFMHA was to advance the field for individuals who partner with equines to promote human growth and development. Over its fourteen year history, EFMHA helped develop the standards for Equine Facilitated Psychotherapy, the Psychosocial Safety Guidelines for PATH Intl. Centers, an EFMHA Bibliography which is updated every two years, an instructional product for how to start an EFP/EFL program, an EFMHA list serve group which now serves over 1,200 members and the Equine Specialist in Mental Health and Learning Workshop that you are participating in now.

In an effort to more fully embrace the PATH Intl. and EFMHA missions, to more efficiently steward EFMHA and PATH Intl. resources and to ensure inclusion, the Boards of EFMHA and PATH Intl. decided to integrate in May of 2009. The full integration EFMHA and PATH Intl. was accomplished at the PATH Intl. National Conference in Denver November 4, 2010 with both the EFMHA Board and the PATH Intl. Board participating in lighting a “Unity Candle” and the respective Presidents signing the Integration Agreement. The completed integration has seen the acceptance of the certification of an Equine Specialist in Mental Health and Learning, and the resurgence of a committee for Equine Welfare. The integration process required that the EFMHA tenets of “partnering with the horse to help others” and “viewing people holistically,” were included in PATH Intl. philosophy and practice. The resulting Mission Statement, Vision Statement, Core Values, and Code of Ethics include these tenets, see these on page 7.
Equine Facilitated Psychotherapy (EFP)

Fact sheet

Equine Facilitated Psychotherapy is defined as a form of experiential psychotherapy that includes equine(s). It may include, but is not limited to, a number of mutually beneficial equine activities such as handling, grooming, lunging, riding, driving, and vaulting. EFP is a treatment approach within the classification of Equine Assisted Therapy that provides the client with opportunities to enhance self-awareness and re-pattern maladaptive behaviors, feelings and attitudes.

EFP may be used for people with psycho-social issues and mental health needs that result in any significant variation cognition, mood, judgment, insight, anxiety level, perception, social skills, communication, behavior, or learning. Examples may include but are not limited to:

- Anxiety disorders
- Psychotic disorders
- Mood disorders
- Behavioral difficulties
- Other mental illness, such as Schizophrenia, Attention Deficit Hyperactivity Disorder, Autism, Receptive or Expressive Language Disorders, Personality Disorders, Depression, Post Traumatic Stress Disorder, etc.
- Major life changes such as environmental trauma, abuse, divorce, grief and loss, etc.
Vocational Profile of an Equine Specialist in Mental Health and Learning

The Equine Specialist in Mental Health and Learning ensures the safety and well-being of the PATH Intl. center equine participating in equine facilitated mental health and education sessions. She/he (the ESMHL) serves as the equine expert during equine/human interaction. The mental health or education sessions may be mounted or unmounted. In accordance with PATH Intl. if the session is mounted the ESMHL should be assisted by a PATH Intl. certified therapeutic instructor or also hold a PATH Intl. certification in the equine activity being used.

The ESMHL works with mental health or education providers delivering services within the scope of their profession incorporating equines in their practice. The ESMHL has a general knowledge of mental health process. Education standards, guidelines, and definitions are being created; the ESMHL should update themselves on PATH Intl. standards and guidelines regularly.

The ESMHL has a thorough understanding of the ways equine behavior effects human responses and evaluates the role of the equine during mental health or education sessions she/he supervises. The ESMHL maintains responsibility for the equine, assesses the equine’s response to any interactions, and prohibits or stops any activity that compromises the well-being of the equine. She/he ensures that equine interactions are safe an appropriate for the goals of the mental health or education session.
Roles within Mental Health & Learning for Equine Assisted Activities & Therapies (EAAT)

Dually Trained Educator or Mental Health Professional should work alone only on a "case by case" basis, for safety.
Definitions

**THERAPEUTIC:** Of or relating to the promotion of health. In all EFMHL work, whether activity or therapy based, the work with horses and humans is therapeutic. What that means is that our comments to the clients and people coming into our barns should be therapeutic in nature. This means that we as staff have the person’s needs in the forefront and not our own. A therapeutic relationship is not about us. It is about the other. Example: A therapeutic moment for ourselves might be a hot bubble bath with a glass of cognac, for another, in our barns, it might be: not responding back in a hostile manner if the client does so to us.

**THERAPY:** Therapy is an instrument used to relieve or heal a disorder. Only licensed professionals can conduct therapy. That might be an: OT, Speech Therapist or Physical Therapist. These individuals must be certified to conduct therapy and often have to update their training by attending additional trainings each year.

**EFL:**

**PSYCHOTHERAPY:** This is the treatment of mental disorders by psychological rather than medical means. Professionals calling themselves psychotherapists must have specific training that enables them to become licensed in their fields. Only licensed mental health professional can conduct psychotherapy.

Every state requires different credentialing for their mental health license. Practicing as a psychotherapist demands that you continue to learn and grow as a clinician working in this field.

ES has two major focuses: Equine Assisted Activities (EAA) which includes Equine Facilitated Learning (EFL) and Equine Facilitated Psychotherapy (EFP).

EAA activities encompass many different activities involving the equine as a partner in the learning process. It can include: EFL, which promotes personal exploration of feelings and behaviors in an educational format. EFL falls under the heading of Equine Assisted Activities and may be designed and taught by a PATH Intl. Instructor and an Educator. The sessions may be mounted or unmounted. In real life, educators are often not on the premises for a lesson and so, communication with the educator takes place at another time.

EFP promotes personal exploration of feelings and behaviors and allows for the clinical interpretation of such. This requires an appropriately licensed and credentialed mental health professional who is currently practicing psychotherapy. In EFP, the session will have clearly defined goals and objectives set by the MHP in the individual’s Treatment Plan and may be designed and taught by a PATH Intl. Instructor with an Equine Specialist in Mental Health and Learning certification or just an ESMHL a licensed therapist. The sessions may be mounted or unmounted.

If mounted sessions are occurring a PATH Intl. TRI must be directly supervising the activity.

To further clarify the difference between EFP and EFL:

In EFL, as an ES you would design lesson activities that would support specific goals for the individual. You would probably do this planning with a therapist or an educator, but if they have little or no horse experience, then you would definitely have the major responsibility here. Notice that the activities listed here may not look like your typical riding lesson.

If you are providing EFP, then a therapist must be in the session. The therapist might possibly stop the activity the ES is conducting in order to conduct a psychotherapeutic reflection, or he/she might gather the client(s) at the end for the same. The MHP and ES are in continuous dialogue regarding the session.

With an Educator, such as a special education teacher, you might be working on your own, with the educator back in the classroom and not on the premises. In this case you might send the educator notes on the lesson or talk by phone.
Confidentiality

Confidentiality is maintaining privileged information between client and therapist. This might include the client’s feelings and thoughts as well as disclosures of past misdeeds, sexual orientation, affairs, drug use and so forth. In the case of children under the age of 18 who disclose incest or sexual abuse, all personnel are mandated reporters and must call Child Protective Services regarding the situation. It is the therapist’s responsibility to inform the client, parents or other concerned parties that reporting child abuse is the law.

Records/case notes are kept separate from other files and viewing is limited to the therapist and whomever the client wishes to see them. A release of information form is required for this to occur. Each state has a required amount of years for the files to be kept before they might be disposed. Records must be kept in compliance with the above law.

EFMHL programs afford a unique situation that might stretch rules of confidentiality. The Equine Specialist in Mental Health and Learning may be given private information of a client who does not want it repeated to the therapist. It is the ESMHLs job, however, to remind the client of the guidelines that state that anything suicidal, homicidal or illegal must be reported and discussed. A minor child may have his parents involved and so must know this and be told it is for his protection. Therapist-ES discussion of client issues needs to be addressed (with client, parent, group home, etc.) as necessary for continuity of care and to plan the most appropriate intervention.

Ultimately, it is the mental health professional’s job to maintain confidentiality. It is wise to inform participants in advance that due to the nature of the therapist-riding instructor-client relationship as well as the open barn atmosphere, strict confidentiality cannot be provided and should not be expected.
HIPAA Compliance

The American Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a set of rules to be followed by health plans, doctors, hospitals and other health care providers. HIPAA took effect on April 14, 2003. In the health care and medical profession, the great challenge that HIPAA has created is the assurance that all patient account handling, billing, and medical records are HIPAA compliant.

Some provisions of the HIPAA involve patient/hospital interaction. For example, patients must be able to access their record and correct errors and must be informed of how their personal information will be used. Other provisions involve confidentiality of patient information and documentation of privacy procedures. It is these provisions that have led to regulation-specific software updates, specialist consulting, and in some cases complete overhauls of medical billing and records systems (http://www.tech-encyclopedia.com/hipaacompliance.htm).
The Diamond Model

What comes from each impacts the other.

Developed by: Dr. Susan Brooks from Geen Chimeys and Dr. Leslie Mcullough from Legends Equestrian

Animal (Animal Behavior)

Equine Specialist

Client or Group

Therapist, Teacher
The Triangular Model

To teach relationship in working with animals in a structured manner.

Developed by: Dr. Susan Brooks from Geen Chimeys and Dr. Leslie Mcullough from Legends Equestrian

What comes from each impacts the other.
Treating the Equine as a Partner Rather than Tool

Treat equine partners with respect:

Awareness of emotional needs-more than good physical care:

Equines often reflect our behavior:

Congruency:

Connection:

We must take responsibility for keeping them safe in this setting.
Name: Deric (male)  DOB: 01-17-1992  Date: 01/11/09

**Diagnosis:** conduct disorder; bipolar disorder; ADD

**Reasons for seeking therapy:** anger, poor self control/self-regulation, narcissism/entitlement, self-defeating attitude

**Primary Goal:** self control; anger management; poor attitude  
*Objective:* improved relationships with everybody; return to regular school; improved self esteem/self image  
*Interventions:* learn breathing techniques (horse breath) & other coping skills; find reasons to exercise self control- weigh costs and benefits of losing temper; work on increased frustration tolerance with horse, then practice with family

**Emotional/Personal Goal:** self/mood regulation (bipolar); discover personal strengths, interests and a willingness to build on these  
*Objective:* improved overall life satisfaction (social, home, school, etc.)  
*Interventions:* learn my patterns of highs and lows, learn coping strategies to help reduce problematic extremes; work with horse to discover and develop strengths including a willingness to give as well as take

**Behavioral Goal:** respect for others including “other awareness” and accepting that; self control in all aspects of my behavior including sexual  
*Objective:* to become more pro-social, to gain my parent’s trust so that I have more independence; to get along with others better  
*Interventions:* learn respect for horse by attending to his needs, then practice this at home, school, etc.; consider joining ROTC so that I practice these behaviors regularly

**Academic/Job Goal:** finish school (graduate); go to trade school/consider the military, beginning with ROTC, cooperate with teachers  
*Objective:* stay in regular school, learn what I need to learn; work at something I love  
*Interventions:* work with horse to learn perseverance; finish what I start (horse, school)

**Social Goal:** make more pro-social friends/stay away from negative peers, places, etc.  
*Objective:* stay out of trouble, get more + respect and trust; have real friends  
*Interventions:* work with horse to learn reciprocity; problem solve ways to make new friends, beginning with interacting with kids at therapy, ROTC, other pro-social places

**Family Goal:** gain parent’s trust; learn to get along with younger brother  
*Objective:* to have more independence; have a better relationship  
*Interventions:* gain horse’s trust and maintain it by being respectful, consistent and learning to let him/others know what I am doing (going to do); practice honesty in every situation I am in (home, school, social), especially with my family

**EFP (horse-related) Goal:** develop a relationship with my horse that will teach me how to have better relationships with everyone else; learn how to ride

_____________________________________________   _____________________________________________
Client  Therapist
Name: Taylor (female)  DOB: 12/31/1996  Date: 11/20/2008

**Diagnosis:** bipolar, RAD, ODD, ADHD; has developmental skill delays

**Reasons for seeking therapy:** poor impulse control; self-defeating behaviors; poor relations including family, school, peer; narcissism and lying

**Primary Goal:** improved self-regulation (reduce hyperactivity), cooperation, age-appropriate functioning; learn to interact with others and care about their feelings

*Objective:* improved relationships that will invite more opportunities to make connections, feel a part of something special so that there is reason to change (self regulate, think about others, etc.); learn to respect self and others

*Interventions:* learn and practice self-calming techniques incl. horse breath, self-breaks, etc. at therapy and use them at home/school; practice “other awareness” in order to work with her horse and then take this into other aspects of her life

**Emotional Goal:** self-regulation incl. significant reduction in hyperactivity that is used to avoid feelings, interpersonal relations, intrusive thoughts, etc.

*Objective:* improved self-esteem/concept, more able to make decisions, take responsibility, attend to personal and interpersonal needs; self-control

*Interventions:* work with horse such that when she becomes stressed Taylor times herself out, breathes, problem solves and returns to work; practice this at home

**Behavioral Goal:** impulse control, accepting limits, taking responsibility; honesty

*Objective:* to make it more feasible to have friends and privileges at home; feel better about self and to act in a more age-appropriate manner; discover the + in truth telling

*Interventions:* learn to respond to horse’s setting of boundaries by backing off and processing his response to her impulsivity/insensitivity – learn that these two go hand-in-hand; be given incrementally more responsibility with horse/horse care that will be imitated at home with increased responsibilities and rewards for compliance

**Academic/Job Goal:** compliance with teachers and school expectations; self control

*Objective:* increased success at school/with school work; improved school relations

*Interventions:* expectation of compliance @ therapy, tying riding and/or consequences to performance at school

**Social Goal:** treat others with respect, tell the truth, and act like a friend to make friends

*Objective:* make friends; feel good about self for having others like her

*Interventions:* work with horse/barn peers/personnel to learn socializing/interactions and practice with feedback; homework for school/family socializing

**Family Goal:** respect, honesty, cooperation, rule compliance

*Objective:* if Taylor can act like part of the family she may begin to feel like part of the family; increased trust and privileges

*Interventions:* EFP; homework to work/play in pairs at home; cooperation tied to riding

**EFP (horse-related) Goal:** build a relationship with horse that will translate into life

_____________________________________________   _____________________________________________

Client  Therapist
Name: _____________________________________ DOB:___________________ Date: _____________________

Diagnosis:__________________________________________________________________________________

Primary issue bringing client to therapy:

Primary Goal:
Objective:

Interventions:

Emotional Goal:
Objective:

Interventions:

Behavioral Goal:
Objective:

Interventions:

Academic/Job Goal:
Objective:

Interventions:

Social Goal:
Objective:

Interventions:

Family Goal:
Objective:

Interventions:

EFP (horse-related) Goal:

_____________________________________________   _____________________________________________

Client  Therapist
Sample Individualized Education Program (IEP)  
2003-2004

In compliance with federal and state regulations this document may not be disclosed to any other person.

Student and Guardian information

Student Name: Birth Date: Committee Date:
Native Language: Translation: ID #:
Address: Zip: Gender:
State: City: County:
Home #: Special Alerts:
Guardian: Native Lang: Day #:
Relation:

Recommended classification and placement information

Disability: Decision:
School: Grade:
Projected Start: End by:
Review By: Reevaluation by:
Special Transport:
Second Language:
State Testing:
Extended Year:

How the student's disability affects involvement and progress in the general education curriculum

Recommended programs and services

<table>
<thead>
<tr>
<th>Program/Service</th>
<th>Start</th>
<th>End</th>
<th>Ratio</th>
<th>Freq</th>
<th>Period</th>
<th>Duration</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential School</td>
<td>09/03/2003</td>
<td>06/25/2004</td>
<td>8-1+1</td>
<td>5</td>
<td>Daily</td>
<td>6 hr</td>
<td></td>
</tr>
<tr>
<td>Counseling</td>
<td>09/03/2003</td>
<td>06/25/2004</td>
<td>1-1</td>
<td>1</td>
<td>Weekly</td>
<td>30 min</td>
<td>Special</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>09/03/2003</td>
<td>06/25/2004</td>
<td>1-1</td>
<td>2</td>
<td>Weekly</td>
<td>30 min</td>
<td>Special</td>
</tr>
</tbody>
</table>

Extended School Year Information

Program modifications, testing accommodations, supports, assistive technology or adapted devices including the consideration of any special factors such as Braille, behavior interventions, communication needs, and English language proficiency.

Program modifications and/or supports for personnel

Testing accommodations (except as prohibited by state education department policy)
Extended time (2.0); directions explained; administer in a small group

Extent of non-participation in regular education and least restrictive environment statement

Extent of non participation
Least restrictive environment

Educational achievement and learning characteristics- Levels of development in subject and skill areas, including, cognitive function, learning style, rate of progress and, if appropriate, activities of daily living and adaptive behaviors.
Levels/abilities

Needs

Standardized test results

<table>
<thead>
<tr>
<th>Date</th>
<th>Test</th>
<th>Sub test</th>
<th>Score/type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/02/2002</td>
<td>Wechsler intelligence scale for children III</td>
<td>Verbal</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Performance</td>
<td>121</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Full scale</td>
<td>106</td>
</tr>
<tr>
<td></td>
<td>Wide Range Achievement Test</td>
<td>Written Decoding</td>
<td>2nd</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Numerical computations</td>
<td>2nd</td>
</tr>
</tbody>
</table>

Social Development:
Levels of development in relationships with peers and adults, self-concept, social adjustment to the school and community environment, and behaviors that impede the learning process.

Levels/Abilities
The student has some problems relating appropriately to peers. The student actively participates when feeling comfortable. The student does not interpret and follow social cues.

Needs
Management needs:
- Levels of teacher support, supervision, environmental structure and, if appropriate, behavioral interventions or strategies required to address learning, social and physical needs.

Needs
- The student requires small group instruction to focus on tasks. The student needs teacher redirection to stay on task.
- The student needs a structured environment.

Committee Meeting Information
Committee: Committee on Special education  Meeting Date:
Reason: Annual review
Attendance:

Comments: CSE met to review program and progress.
Based Upon: Psychological evaluation, 01/02/2002; Occupational therapy evaluation, 06/20/2003

Annual goals and short term objectives (progress to be reported 4 times during the school year)

Study Skills

Demonstrate an improvement in attending skills necessary to learn effectively in the school environment and progress toward achieving the learning standards.

1. Demonstrate the ability to exhibit appropriate behaviors to enhance listening skills (e.g. posture, eye contact) with 85% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher, by June 15.
2. Demonstrate the ability to maintain attention to task during seatwork activities in the classroom with 85% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher, by June 15.
3. Demonstrate the ability to attend the classroom activities to complete the tasks with 85% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher, by June 15.
Reading

**Demonstrate an improvement in comprehension skills necessary to read for information and understanding.**

1. Identify and use specific vocabulary words at his instructional grade level used in the classroom with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher, by June 15.
2. Demonstrate the ability to understand the main idea in a given passage with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher, by June 15.
3. Demonstrate the ability to correctly answer who, what, where, when and why questions regarding a passage with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.
4. Identify the sequential order of events in a given selection with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.
5. Demonstrate the ability to independently complete classroom reading assignments with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.

Writing

**Demonstrate an improvement in the mechanics of written language such as spelling, capitalization and punctuation necessary to write for information, understanding and written expression.**

1. Identify and recognize incorrect spelling in a given assignment with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.
2. Transition from inventive or creative spelling to conventional forms of spelling in classroom work with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.
3. Demonstrate the ability to apply the rules of spelling to all written work with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.
4. Demonstrate the ability to correctly capitalize and punctuate a written assignment with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.

Mathematics

**Demonstrate an improvement in mathematical concepts, reasoning and computation necessary to develop problem-solving skills and to utilize mathematics to address everyday problems.**

1. Add numbers which require regrouping with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.
2. Subtract numbers which require regrouping with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.
3. Multiply single digit numbers with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.
4. Demonstrate an understanding of time concepts with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.
5. Demonstrate an understanding of money concepts with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.
6. Demonstrate an understanding of measurement concepts with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.
Social/Emotional/Behavioral

Demonstrate an improvement in self-awareness and self-concept

1. Demonstrate the ability to verbalize how a person's self-concept affects his behavior with 85% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.
2. Demonstrate the ability to identify his feelings of frustration when they occur with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.

Motor

Demonstrate an improvement in activities which require fine motor coordination and manipulation of classroom materials and equipment needed to participate in educational activities.

1. Demonstrate the ability to use a “pencil grip” to facilitate an appropriate grasp during writing activities with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.
2. Demonstrate improved speed and motor skill in using an assistive pencil grip with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.
3. Demonstrate the ability to maintain adequate pressure on the pencil or pen during writing tasks with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.

Demonstrate an improvement in activities that require visual-motor coordination and visual perceptual skills needed to participate in education activities

1. Demonstrate the ability to identify differences in visual details with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.
2. Demonstrate improved memory for visual information with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.
3. Demonstrate the ability to reproduce three-dimensional block designs from a picture with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.

Demonstrate an improvement in sensory processing skills to successfully participate in educational and classroom activities.

1. Demonstrate the ability to work with various textures (e.g. glue, sandpaper) while participating in educational activities with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.
2. Demonstrate the ability to continue to work in the presence of sound and visual stimulation in the classroom with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.
3. Demonstrate the ability to respond appropriately in the classroom to various auditory demands (e.g. teacher, fire, alarm, and intercom) with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.
4. Demonstrate the ability to attend to tasks and follow directions in order to complete writing activities with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.
5. Demonstrate the ability to calm self and control non-purposeful movements while performing a desktop activity with 80% mastery, evaluated by utilizing recorded observations, as assessed by the special education teacher by June 15.
Sample Lesson Plan

Instructors Name: Mary
Class: Time: 1:00 pm
Date: 10/15/03
Participants: Joe Student, Jim Scholar

Therapy/Education Goals:
1. Increase appropriate interpersonal peer relationship skills.
2. Improve ability to follow directions from adults.
3. Increase ability to focus on the task at hand.

Lesson Objective:
1. Participants will describe and respond to communication from the horse and each other.
2. Participants will share the task of grooming by discussing and deciding who will do which task.
3. Participants will recognize and decode 70% of horse behavior that indicates his opinions about their actions (swishing tail, ears back vs. relaxed body, leaning into itches he likes, etc.

Preparation/Equipment needed:
Jerry (horse) is clearly swishing his tail and moves away from touch he does not like and leans in to touch he does.
Grooming box with curry comb, hoof pick, soft brush, and mane brush.

Other People Needed? Sam Counselor, MSW

Lesson Content/Procedure (include sequence of activities, etc.)
1. Observe horse herd. Talk about how horses indicate annoyance, comfort, etc. Discuss how horses have itchy places that they like scratched and other places that they don't like touched. Observe horses' response to flies, etc.
2. Introduce grooming tools and process. Allow students to curry and brush their own skin to figure out what feels good and what doesn't. (5 minutes)
3. Introduce participants to Jerry. Talk about how they can figure out what Jerry likes and does not like. (5 minutes)
4. Help participants decide how they will accomplish the task of grooming. They will decide whether to do one tool at a time, one student on one side, or any other safe way of organizing the task. Divide up hoof cleaning. Focus will be on Jerry's responses rather than getting the horse clean.
5. Groom Jerry. Ask them to observe and comment on his responses to their efforts
6. Participants decide which grooming activity Jerry liked best. Do that for him again for 5 minutes at the end.
7. Process sharing the task, working together, horses' response to their work.

Summary and Evaluation:
Joe and Jim were impatient with the herd observations so we cut them short. They liked the grooming tools, and had trouble waiting for direction in the grooming task. They disagreed over who would brush and who would curry, but solved it by having each one do one side of the horse. Joe actually liked cleaning hooves and showed Jim how to pick up and put down the hoof. Jerry moved away from attempts to brush his ears, but made great faces while having his belly curried. Both boys were able to interpret his responses with assistance. They agreed that he liked the belly scratching best, and took turns doing that for him at the end of the session.

In processing they decided that they liked grooming Jerry, and trying to read his behavior. Sam suggested that they practice reading behavior by meeting him to watch students in the cafeteria.

Plans for Next Lesson: Have the boys give Jerry a bath. Continue to work on cooperative efforts and sensitivity to horse responses.
<table>
<thead>
<tr>
<th>Subject:</th>
<th>Grade:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lesson topic:</td>
<td>Class:</td>
</tr>
<tr>
<td>Teacher:</td>
<td></td>
</tr>
<tr>
<td>Learning or therapy goals:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objectives:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Procedures:</th>
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</table>

<table>
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<tr>
<th>Resources:</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Assessment Plan:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Student Work:</th>
</tr>
</thead>
</table>

A layman’s look at DSM-IV-R Categories:  
Dominant Diagnoses Found in EFHM/EFP Programs

By: Leslie McCullough, LCSW, LSOTP*
Legends Equestrian Therapy

Outline

**Topic 1: Learning Disabilities Part I & II- Areas to focus on when working with individuals.**

- Processing Information
- Academic
- Social/Emotional
- Life Skills

**Topic 2: ADD-vs.-ADHD**

- How they are defined
- Differences
- Similarities
- Oppositional Defiant Disorder
- Conduct Disorder

**Topic 3: Mood Disorders**

- Depression
- Dysthymic Disorder
- Bi-Polar Disorder
- Anxiety Disorders
- PTSD
- OCD
- Personality Disorders
- Borderline Personality Disorder
- Narcissistic Behavior
TOPIC #1: Learning Disabilities Part I-Areas to focus on when working with individuals.

Processing Information:
General areas of processing deficiency include:
- Language/Memory
- Visual/Perceptual
- Motor Skills

Most common problem areas include:

Academic Examples:
- Difficulty recalling events
- Oral expression below same age peers
- Difficulty memorizing information
- Doesn’t recognize letters/words
- Difficulty interpreting words
- Poor penmanship or difficulty writing
- Needs to concentrate on tasks that are usually automatic

Social/Emotional Examples:
- Misinterpreting oral communication
- Misreads nonverbal cues such as facial expression or voice intonations
- Violates personal space and may not make eye contact
- Misunderstands figurative language or jokes; may not know when being kidded or scolded
- Multiple meanings of words
- Trouble following game rules
- Strategizing, trouble seeing another’s point of view
- Socially immature; may respond like a younger child overall
- May not get along with peers who are the same age
- Handles changes in routines poorly
- Resiliency becomes lower when sick, tired or stressed.

Life Skills:
- Poor listening
- Comprehension
- Difficulty with oral directions and sequencing events
- Poor at self advocacy skills such as requesting help or seeking clarification
- Organizational problems – Loses things and has difficulty sorting out problems
- Difficulty problem solving, lacking the knowledge to break down a situation/task into specific steps
- Gets lost easily, has trouble reading maps or following pictorial information
- Delayed sense of time
- Poor estimating skills; can not judge how long a task may take
- Trouble dressing self-buckling, zipping and tying
- Poor table manners
- Physical exercise can be difficult and disliked
**TOPIC #2: ADD-vs.-ADHD**

Definition of **ADD/ADHD**: A persistent pattern of inattention and/or hyperactivity that is more frequent and more severe than is typically observed in individuals at a comparable level of development.

Comparisons of **ADD** and **ADHD**:

<table>
<thead>
<tr>
<th>ADD (Inattentive)</th>
<th>ADHD (Impulsive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty following directions</td>
<td>Is fidgety</td>
</tr>
<tr>
<td>Has difficulty keeping attention on tasks or play activity</td>
<td>Leaves when they shouldn’t</td>
</tr>
<tr>
<td>Loses things necessary for tasks and activities</td>
<td>Runs or climbs inappropriately</td>
</tr>
<tr>
<td>Doesn’t listen</td>
<td>Talks excessively</td>
</tr>
<tr>
<td>Fails to give close attention to details</td>
<td>Has difficulty playing quietly</td>
</tr>
<tr>
<td>Seems disorganized</td>
<td>Is always on the go</td>
</tr>
<tr>
<td>Has trouble with tasks requiring long term mental effort</td>
<td>Has trouble waiting his/her turn</td>
</tr>
<tr>
<td>Is forgetful and easily distracted</td>
<td>Interrupts</td>
</tr>
</tbody>
</table>

Low frustration tolerance  
Temper outbursts  
Bossiness  
Stubbornness  
Excessive and frequent insistence that requests be met  
Mood ability (abnormal variability)  
Easily demoralized  
Sadness, anxiety and irritability  
Poor self esteem  
Often rejected by peers  
Impaired academic achievements/devalues school

**Learning Disabilities Part II**

**Oppositional Defiant Disorder**: (DSM-IV Classification) Essential features are a recurrent pattern of negativistic, defiant, disobedient and hostile behavior toward authority figures.

**Indicators of this disorder include**:  
Losing temper  
Arguing with adults  
Actively defying or refusing to comply with the requests of rules for adults  
Deliberately doing things that will annoy other people  
Being easily annoyed by others  
Being angry and resentful  
Being spiteful and vindictive

**Conduct Disorder**: (DSM-IV Classification) The Essential feature is a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated.

**Indicators of this disorder include**:  
Aggression to people and animals  
Bullies, threatens or intimidates others  
Initiates physical fights  
Has used a weapon that can cause serious physical harm to others  
Has been physically cruel to people  
Has been physically cruel to animals  
Has stolen while confronting a victim (mugging, etc.)
Has forced someone into a sexual activity
Destruction of property, includes setting a fire
Deceitfulness or theft, burglary, car theft, lies, cons and shoplifting
Serious violation of rules, runaways, truancy, curfew violations

*The continuum often looks like this:
ADD/ADHD OPOSITIONAL DEFIANT CONDUCT DISORDER DELINQUENCY?

**TOPIC #3: Mood Disorders**

**Major Depression**: (DSM-IV Classification) A medical disorder that, day after day, affects a person’s feelings, physical health and behaviors. Major depression is not just feeling “The Blues” or “Down in the Dumps”. It is pervasive and can occur even when life is going well.

**Common Symptoms Include:**
- Significant weight loss or gain
- Trouble sleeping or sleeping too much
- Fatigue and loss of energy; lack of enthusiasm
- Feeling of worthlessness; hopelessness and/or sadness
- Psychomotor agitation or retardation
- Poor concentration
- Overreaction to criticism
- Poor self esteem
- Anger or rage
- Suicidal ideation/plans

**Dysthymic Disorder**: (DSM-IV Classification) Dysthymia describes a chronically depressed mood that occurs for most of the day, more days than not for at least 2 years.

**Common Symptoms Include:**
- Poor appetite or overeating
- Insomnia or hypersomnia
- Low energy
- Poor concentration or ability to make decisions
- Feelings of hopelessness

**Bi-Polar Disorder**: (DSM-IV Classification) Also known as manic-depression, Bi-Polar is a disorder of the brain. There are mood swings with some degree of depression alternating with periods of mania or elation.
<table>
<thead>
<tr>
<th>Adult Symptoms</th>
<th>Child/Adolescent Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manic Phase</td>
<td>Chronic behaviors, mixed irritability</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>Outbursts of destructive rage</td>
</tr>
<tr>
<td>Explosive Anger</td>
<td>Distractibility</td>
</tr>
<tr>
<td>Impaired judgment</td>
<td>Impulsivity</td>
</tr>
<tr>
<td>Increased spending</td>
<td>Hyperactivity</td>
</tr>
<tr>
<td>Increased sex drive</td>
<td>Dissociative symptoms</td>
</tr>
<tr>
<td>Aggressive behavior</td>
<td>Racing thoughts</td>
</tr>
<tr>
<td>Grandiose notions</td>
<td>High energy</td>
</tr>
<tr>
<td>Delusions</td>
<td>Aggression</td>
</tr>
<tr>
<td>Increased energy</td>
<td>Grandiosity</td>
</tr>
<tr>
<td>Exaggerated sociability</td>
<td>Egocentricity</td>
</tr>
<tr>
<td>Risky behavior</td>
<td>Loss of reality testing</td>
</tr>
<tr>
<td>Depressed Phase</td>
<td>Tells “Tall Tales”</td>
</tr>
<tr>
<td>Physical Debilitation</td>
<td></td>
</tr>
<tr>
<td>Loss of interest in usual activities</td>
<td></td>
</tr>
<tr>
<td>Eating and Sleep disturbances</td>
<td></td>
</tr>
<tr>
<td>Decreased appetite</td>
<td></td>
</tr>
<tr>
<td>Poor Concentration</td>
<td></td>
</tr>
<tr>
<td>Hopelessness</td>
<td></td>
</tr>
<tr>
<td>Suicidal Ideation</td>
<td></td>
</tr>
</tbody>
</table>

**Anxiety Disorders: Types**

- Generalized Anxiety Disorder
- Panic Disorder
- Specific Phobias
- Obsessive-Compulsive Disorder (OCD)
- Post Traumatic Stress Disorder (PTSD)

**Symptoms common to all:**

- Difficulty concentrating
- Muscle Tension
- Sweating or hot flashes
- Irritability
- Sleep disturbances
- Trembling or shaking
- Heart palpitations
- Nausea or abdominal distress
- Shortness of breath
- Chest pain
- Feeling dizzy, unsteady or light headed
- Fear of losing control or going crazy
- Numbness or tingling
- Depersonalization and derealization

**OCD:**

- Repeated rituals (Hand washing, counting)
- Preoccupation with symmetry
- Persistent thought of sexual thought or thoughts that go against the person’s belief system
- Aggressive impulses such as hurting one’s child
- Repeated doubts (Left door unlocked or iron on)
PTSD:
Self destructive and impulsive behavior
Dissociative symptoms
Feelings of ineffectiveness
Shame, despair and hopelessness
Feeling permanently damaged
Hostility
Somatic complaints
Impaired relations; withdrawal

Personality Disorders: (DSM-IV Classification) An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture.

Borderline: There is a pervasive instability of interpersonal relationships, self-image and mood. Abrupt mood changes, stormy relationships, unstable and fluctuating self image, unpredictable and self-destructive actions are common. “Splitting”, where a person or thing is all good or all bad or good today and bad tomorrow speaks to the borderline’s difficulty with object constancy. Self mutilation in response to internal distress occurs frequently.

Narcissistic: There is a pervasive pattern of grandiosity, a need for admiration and lack of empathy. These individuals have a grandiose sense of self-importance, and routinely overestimate their abilities and inflate their accomplishments, often appearing boastful and pretentious. They need constant attention and have a fragile self-esteem.

References


*For a more complete discussion on these diagnoses including EFMH/EFP related interventions, contact Leslie McCullough Moreau to inquire about purchasing her book.
Learning Styles

Characteristics of the Auditory Learner
- Remember what they hear better than what they see.
- Has limited attention to visual tasks.
- May have poor handwriting.
- Respond better in class when hearing, rather than reading.
- Love to have stories read to them with a lot of expression.
- Tend to memorize well and remember spoken words and ideas.
- Often surprise their friends by knowing all the words to songs. They also enjoy rhythmic and musical activities.
- Are talkative. They may share jokes, amuse peers with tall tales and drive parents to distraction with incessant chatter.
- Might have poor visual memory, reversing letters p and q, b and d, n and v.

Auditory Learners Learn Best When They......
- Talk through the steps of a task, and learn how to think, spell and say syllables out loud.
- Choose oral over written reports.
- Listen to books on tape.
- Ask you or their teacher to tape book or chapters of books.
- Hear information in the classroom first, then read the related material and, finally make up their own story about the material.
- Make sure the teacher knows they need to hear the assignment as well as see it on the blackboard.
- Use travel games to give their memory a workout. One simple but effective game is, “I’m going on a trip and on my trip I will take...” Each person repeats the preceeding items and adds one more. Car rides are also perfect times for auditory learners to recite multiplication facts.

Characteristics of the Visual Learners
- Retain what they see better than what they hear.
- Respond better when you show them things rather than tell them.
- May seem to ignore verbal directions.
- May say “What?” or “Huh?” often.
- Seem to misunderstand often.
- Asks for questions or instructions to be repeated, frequently in different words.
- May frequently have a “blank” expression on face, or may seem to daydream during classes that are primarily verbal.
- May have poor speech, in terms of either low vocabulary, poor flexibility of vocal patterns or articulation.
- Loves books, pictures and puzzles, and are attracted to colors.
- Have very good visual recall, and can remember where they placed a toy days earlier.
- Are noticeably quiet in class.
- May watch the expression on your face when you speak or read to them.
- Are detail oriented and generally keep their rooms tidy.
- Have a hard time remembering the order of the alphabet unless they recite it from the beginning.

Visual Learners Learn Best When They....
- Use many visual aids - color coding, charts, maps, graphs, flashcards, highlight markers, photos.
- Take advantage of visual gifts. During museum visits, for example, they can build critical thinking skills by comparing and contrasting paintings and objects.
- Watch the facial expressions of people who are reading to them.
- Have plenty of books and magazines around the house.
- Read materials first, and then attend a classroom lecture.
- Play educational computer games and other games that encourage strategy and critical thinking, such as chess, Scrabble and Concentration.
**Characteristics of Kinesthetic Learners**

- Tend to be well coordinated.
- Like to touch things.
- Thrive with hands-on activities such as arts and crafts, science, and building projects.
- Enjoy taking objects apart and putting them back together.
- Learn best by experiencing their environment, they love field trips.
- Don’t mind taking notes.
- Learn concepts well through manipulating- anything that they can hold and change, such as Legos or three-dimensional plastic numbers.
- May become frustrated when learning abstract symbols. They might have a tough time understanding a teacher who says “two plus two equals four.” But they’ll grasp the concept easily if the teacher shows them four marbles.
- Need movement; can’t sit still long.

**Kinesthetic Learners Learn Best When They....**

- Tap out syllables and numbers.
- Draw letters or numbers with crayons on a washable vinyl place mat. Then, they can trace the letters or numbers with raisins or macaroni.
- Review facts in combination with a physical activity. For example, might ask them to recite the names of the presidents while bouncing a ball or riding a stationary bike.
- Color-code vowels and consonants in spelling words, write facts in the air.
- Use a lot of three-dimensional learning aids, such as flashcards. Might spell out words on the refrigerator using magnetic letters. Then ask the children to scramble and unscramble the letters.
- Turn theory into practice, instead of memorizing $2 + 3 = 5$, can learn the concept by using five marbles or five popsicle sticks.
- Play movement-orientated games such as “Where in the World is Carmen San Diego?” and board games with movement. Twister, for example, helps young children learn colors.
- A well executed riding lesson will teach to all three learning styles.
- The horse teaches to the kinesthetic learner.
- The instructor teaches to the auditory learner.

**References**
Additional References

The team consists of at least the Equine, and Equine Specialist in Mental Health and Learning and a Mental Health Professional or Educator working with the Client or Student respectively. The partnership can take many forms.

The Mental Health Professional or Educator may be credentialed as follows:

- Psychiatrist
- Psychologist
- Social Worker
- Mental Health Nurse Practitioner
- Guidance counselor
- Special education teacher
- Life Skills Coach
- May be dually trained as a horse professional/ESMHL.

The Equine Specialist in Mental Health and Learning is:

- Considered the professional regarding horse behavior
- One who designs the lesson and conducts parts or all of it in cooperation with a therapist or educator and their goals for the lesson
- The equine advocate
- Able to assist with experiential learning
- Able to assist a mental health professional in EFP sessions
- An experienced horse person
- Able to demonstrate skill-based knowledge of humane equine handling & management standards and practices
- Familiar and has a working knowledge of PATH Intl. standards
- Capable of evaluating the equine mental/emotional/physical status in terms of its impact on participant safety
- Able to manage single and multiple equines in a variety of settings with varying numbers of people
- Able to demonstrate equestrian skills in horse management and handling as defined by Pony Club C

The Equine Specialist in Mental Health and Learning is not:

- To diagnose the client/student
- To use the horse as a tool to evoke responses from the client/student
- To do EFP work alone
**Emotional Congruency**

Ann C. Alden, MA

In the spring of 1992, I was working at Sierra Tucson’s Adolescent Unit in the STIRRUP Program where we conducted Equine Facilitated Psychotherapy and Equine Facilitated Learning sessions daily. I had the weekend off to study for my PATH Intl. Advanced Certified Level Instructor exam to be given Sunday morning, after completing a weekend long PATH Intl. instructor training workshop. On Saturday, I came home from TROT (Therapeutic Riding of Tucson) to find my 14 year old gray, Anglo-Arabian gelding experiencing colic. The vet came and assured me he would be okay, but I sensed she was wrong even as he seemed to improve.

Sunday morning I took my certification exam (which I passed) and returned home to find Desert Wynd in dire distress. The veterinarian arrived to put him down from what turned out to be an enterolith, or stone, as it is commonly called in the southwest. The stone had caused the colic and he was thrashing in pain, banging against the corral panels as we struggled to get the needle in him to release him from his agony. Finally, after several steel panels were crumpled and knocked down, we succeeded in ending the trauma.

The next day I had to go to work at Sierra Tucson. A group of eight teenagers appeared that morning for their session in the barn. At the opening circle I acknowledged my sadness and grief at my horse’s traumatic death the day before. What I did not acknowledge to myself or the group was the anger I felt at the pain and suffering Desert Wynd had to endure as he died.

We were working in teams in the round pen when a gray Arabian named Count Regal taught me a valuable lesson about being emotionally congruent. One of the teens was mounted bareback on Count and two others were on either side of him acting as sidewalkers. As I tried to lead him around the round pen he kept crowding me, something he had never done before. As he continued to invade my space, as I saw it, I got more and more annoyed and tense until I shot my right elbow into his neck to get him to move over. Startled, he jumped away from me, almost losing his rider. I was shocked and amazed at the force that came from my elbow. Immediately the girls confronted me and said “What did you do that for?” as my face turned red from shame.

Taking a deep breath and hesitating before I spoke, my thoughts were racing. I knew my actions were inappropriate with the horse. I could either cover up and excuse my actions to try and save face or I could come clean with myself, the horse and the adolescents. “I did not mean to hit him so hard” I said. “I was mad at him for not moving over so I tried to push him over. Instead, the anger I’m feeling from Desert Wynd’s death shot out my elbow into Count Regal. I didn’t realize I was feeling so angry until now. I projected my anger onto the horse. I need to make amends to Count Regal for taking my anger out on him”.

Feeling rather self-conscious, I verbally apologized to Count Regal in front of the group. To my amazement, Count Regal’s eyes softened immediately and the kids commented on the change in his demeanor, acknowledged and validated my anger and admitted that they, too, have taken their anger out on others in inappropriate ways. This led to a discussion of sideways anger and passive – aggressive responses to other people and situations, and how being emotionally congruent and assertive is a much healthier way to live. As the ESMHL here it was my job to model to the adolescents how to be fully present and emotionally congruent with them, myself and the horses we were working with that day. Dr. Susan Brooks from Green Chimneys calls this the concept of “being with” by bringing our whole self to another without merging and without using power-over behavior or under power.

We continued the round pen session and Count Regal was a gentleman respecting my space for the rest of the morning. That was the only time I ever had any trouble with him crowding the horse handler. Was Count Regal mirroring back to me my anger in a way that would force me to look at it? Anything is possible. I believe he sensed my emotional incongruence and that had an impact on him as well as on me and the rest of the group. The point is that I got the message I needed to get, and we all learned a valuable lesson that day about the importance of being in touch with all of our emotions and finding healthy ways to process and experience them around others.
Experiential Learning Principles
Ann C. Alden, MA

1. Effective experiential learning will affect the learner’s cognitive structures (action theories), attitudes, values, perceptions and behavioral patterns.
2. People believe more in knowledge discovered themselves than in knowledge presented by others.
3. Learning is more effective when it is an active rather than a passive process.
4. Acceptance of new action theories, attitudes and behavioral patterns cannot be brought about piecemeal; one’s whole cognitive-affective-behavioral system must change.
5. It takes more than just information to change actions, thoughts, attitudes and behavior patterns.
6. It takes more than first hand experience to generate valid knowledge. A theoretical system is required.
7. Behavior changes will be temporary unless the action theories and attitudes underlying them are changed.
8. Changes in perception of oneself and one’s social environment are necessary before changes in actions, thoughts, attitudes and behavior take place.
9. The more supportive, accepting and caring the social environment, the freer we are to experiment with new behaviors, attitudes, actions and thoughts.
10. Both the person and social environment must change for other changes to be permanent.
11. It is easier to change in a group than when alone.
12. We accept new systems of action, thought, attitude and behavior patterns when we accept membership in a new group.

Carl Rogers: Experiential Learning (EL) addresses the needs and wants of the learner. The qualities of EL include: personal involvement, self-initiated, evaluated by the learner and pervasive effects on the learner. Rogers believes that experiential learning is equivalent to personal change and growth. He believes that all human beings have a natural propensity to learn. His principles of experiential learning are:

1. Significant learning takes place when the subject matter is relevant to the personal interests of the student.
2. Learning which is threatening to the self (e.g., new attitudes or perspectives) is more easily assimilated when external threats are at a minimum.
3. Learning proceeds faster when the threat to the self is low.
4. Self-initiated learning is the most lasting and pervasive.

Advantages of Experiential Learning:

1. Use of multiple senses can increase retention of what is learned.
2. Multiple teaching/learning methods can be integrated to maximize creativity and flexibility.
3. Client-centered learning becomes the focus.
4. The process of discovery of knowledge and solutions builds competence and confidence.
5. Learning is more fun for both students and teachers.
6. If clients are more actively engaged in learning, they have a greater stake in the outcome of what they learn and are less likely to become discipline problems.
7. Students can learn life skills that will be used over and over.

Disadvantages of Experiential Learning:

1. A decentralized approach can seem less orderly, and it may be less comfortable to an authoritarian-style teacher.
2. It requires more preparation by the leader/teacher and may require more time for processing.
3. It requires patience and guidance by the instructor/facilitator.
4. There is often no single “right” answer.
**Experiential learning** refers to a style of learning that occurs when a person is interacting with the environment, including the people, animals and situations involved. It is learning by doing and may take place during a short period of time, such as during a workshop, or during regularly scheduled sessions. It promotes personal exploration of feelings and behaviors in an educational format. During experiential learning, one tries out strategies and procedures of an action theory, gets results and feedback, and then organizes present information and experiences into an action theory.

**Equine Facilitated Learning (EFL)** falls under the heading of Equine Assisted Activities and Therapies (EAAT) and incorporates equines into the learning environment. The ability of horses to mirror what humans are experiencing and feeling, their accepting nature and their ability to give immediate, objective feedback to humans combine to create an ideal experiential learning environment. Properly trained ESMHLs in mental health and learning and/or persons dually trained as a PATH Intl. instructor, educators, coaches and therapists may conduct EFL sessions. Understanding equine psychology, behavior and physiology are key ingredients for conducting safe, humane and ethical EFL.

**Equine Facilitated Psychotherapy (EFP)** is a form of experiential psychotherapy that includes equine(s). It may include, but is not limited to, a number of mutually beneficial equine activities such as handling, grooming, lunging, riding, driving, and vaulting. EFP is a treatment approach within the classification of Equine Assisted Therapy that provides the client with opportunities to enhance self awareness and re-pattern maladaptive behaviors, feelings and attitudes. In addition to promoting personal exploration of feelings, attitudes and behaviors, EFP allows for clinical interpretation of feelings, attitudes and behaviors. EFP denotes an ongoing therapeutic relationship with clearly established treatment goals and objectives developed by the therapist in conjunction with the client. The therapist must be an appropriately credentialed mental health professional to legally practice psychotherapy. To practice EFP, the therapist must also have sufficient horse skills to understand and interpret equine behavior and relate it to the client(s).

Concrete experience

(1)

Testing in new situations (4)

Observation & reflection (2)

Forming abstract concepts (3)

David Kolb and Roger Fry

**Action:** The actual performance of some function, the occurrence of a process.

**Attitude:** A learned like or dislike of something or somebody that influences behavior toward that thing or person.

**Cognition:** The process that enables us to imagine, to gain knowledge, to reason about knowledge, and to judge its meaning.

**Experience:** Any event through which one has lived and the knowledge gained from such participation in that event. The sum total of accumulated knowledge.
Qualities of a Good Therapy Horse
Ann C. Alden, MA

In traditional therapeutic riding programs, horses are selected based on temperament, quality of movement, size and training. The first three attributes are primarily innate, but training can usually be added if the horse has the desired qualities otherwise. Horses that are part of an equine facilitated learning (EFL) or equine facilitated psychotherapy (EFP) program also need to be intuitive and willing to bond with the participants and give them safe, objective feedback during the therapy or education session.

The ideal temperament is kind, gentle, intuitive, patient and cooperative. A more high strung, high-energy horse can be an asset to a program if the horse has excellent ground manners and adequate supervision and assistance from a knowledgeable horse person/ESMHL when working with participants. It is important for each horse to be encouraged to develop and express his or her own personality. For any mounted work, the therapy horse should be sound, with three good qualities, and regular gaits. Horses with mild unsoundness, including older, retired horses, often enjoy working with clients during grooming and other ground lessons.

Size, age and breeding are of relatively minor importance. The main requirement is to have a horse that is willing to connect with people and stay focused on the therapeutic process as it unfolds. Because the horse often mirrors what issues are going on with the participant, it is very important to know the horse’s history. Ideally, each horse has been handled with kindness and respect and already trusts people. However, some horses come to equine facilitated mental health and learning programs with a history of neglect or abuse or may have been valued solely for their ability to perform in the show ring and treated only as objects. These issues and others can be related to similar issues experienced by people if the professional horse person/ESMHL knows the horse’s history and can relay that information to the mental health professional. The ESMHL can then “translate” the horse’s behavior to the therapist/educator and the participant as part of the therapeutic/educational process.

Horses that are allowed to develop their own individuality and personality usually thrive in an EFP and/or EFL setting. With practice and coaching from the ESMHL, the horses quickly learn how to be a part of the therapeutic team. They seem to love being encouraged to express themselves in a way that truly helps people understand what they as clients need to work on in the therapeutic environment.
Crisis: Preventing It, Handling It

By Susanne Haseman, MEd, LCMHC

Learner Objectives:
• Participants will describe planning issues that should be addressed to help prevent a student from escalating into crisis.
• Participants will describe how the antecedents of crisis may occur before the rider/student walks into the barn.
• Participants will describe ways to minimize the chances of a student escalating into a crisis mode.
• Participants will describe the general progression from anxiety to acting out crisis to calm afterwards.
• Participants will describe steps to de-escalate a student and repair any damage to relationships.

Therapeutic Riding can provide a wonderful opportunity for someone with a history of acting out to learn how to manage their anxiety, their anger and their frustration. The size of horses, their nonjudgmental nature, and their quick responses can provide very convincing feedback of the need for someone to learn self control, especially someone motivated to come to the barn. But working with this type of participant requires that you do some serious assessment of your facility, your staffing, your potential participants, and yourself.

Where do most crises come from?
Most acting out behavior results from a combination of prior situations and something about the current one that feels in some way threatening, or out of control. A student may have had a fight with their parents as they went out the door at home, and an innocent remark could trigger a huge response. A void in leadership at the barn may be enough to trigger anxiety, or to invite a participant with control issues to try to take over. A conflict between 2 kids in a group that happened at school may spill out into the barn milieu. Generally a huge response to a small problem suggests that there is a larger problem lurking in the participant’s background.

Acting out behavior is generally a message that something is wrong. Misunderstanding that message can often cause the behavior to intensify. Escalation often is the result of a person feeling overwhelmed by:
• Anxiety—a participant may be understandably anxious about being around the horse. Or they may be anxious about their inability to handle the situation. Anxiety causes the brain to bypass good judgment in favor of a fight or flight response.
• Frustration—frustration generally causes us to feel “stupid”, which can be intolerable for many.
• Embarrassment, shame. An adolescent who feels inadequate in a new situation can become volatile, particularly if he or she is embarrassed in front of peers. A person who has very poor self esteem and carries a very heavy load of shame will not be able to tolerate situations where they may be “at fault”, and will try to push blame onto others.
• Trigger responses—reminders or reflections of areas that are very painful for the participant to handle. These can be sensorial (objects, colors, sounds, odors, etc., that reminds them of a past trauma, or is physically difficult for a participant to tolerate), they can be situational (something happens that reminds them of a trauma), and they can be emotional in nature. Or they may be combinations of the above! Often you will have no idea what the trigger may have been and you may need to do some serious reflecting afterwards to figure out what it was.

Preparation and planning
Time spent ahead of time will often determine if acting out is diffused early and safely, or if it will escalate to violence. Do worst case scenario planning, and be sure your set up will be able to manage the worst case. It is well worth the effort!

Before taking on students, evaluate what your facility and staff, etc. can handle. Do you have a quiet and safe space for a “time out”? If you’re going to work with groups, do you have enough people to handle the group and the horses if one participant requires one-on-one attention? Do the kids have a history of needing to be restrained? Are you trained in doing safe restraints? If you aren’t, will someone be coming who is?
Recruit participants who are within your capacity, and turn down those you don’t feel you can manage.

Select your clients carefully. Look at the participants’ histories and level of support from the sending institution. Will someone who can handle an escalation come out to the barn with a participant who has a history of angry outbursts? Do you have horses that can cope with that kind of behavior safely? Clarify roles. If you do not have mental health credentials, remember that you are not the therapist here. Work out ahead of time who would handle what—i.e., in the event of an escalation while the student is on the ground the sending staff would handle it, if it happened while the student was on the horse you’d have to work together. Do some risk management scenario work with the staff.

Consider the size of the group, and whether you have the staff to manage if things become challenging. If it’s a private lesson, you may want the parent there. Be sure you are not alone with a child.

**At the barn…**

Establish that your job is to keep every one safe—the participants, the volunteers, the staff and the horses. You may want to work out some safety rules with the participants before you begin working with horses. Make agreements with the students about what would be safe. Have them help you figure out what the agreements should be. Explain enough about the nature of horses to help them see how their self control will be important.

Every session, before going to see the horses, check out what’s been happening before participants arrived. Talk w/ the transporter about how the ride went. Sending staff may need to handle issues from the trip before the kids get on the horse—another good reason to have sending staff along.

Try to keep the tone of the lesson and the experience positive and fun, but use praise judiciously and carefully—I’ve had some kids who had very negative reactions to praise, because it’s an implied expectation, and expectations were threatening to them.

If a client has been in an escalated state, he/she should not ride until the instructor, client and the sending staff ALL agree that he/she will be safe. Also watch the horse’s behavior. If the horse seems uncomfortable with the participant, there may be a good reason for it. Pay attention.

I don’t believe riders should be forced to ride or work with horses. Grooming can be very calming and grounding. If a participant doesn’t ride and is in a group of people who do, you need to make sure that someone can supervise the non-riders and keep them safe until the others are finished. That issue should be part of your facility/program assessment.

Throughout the interactions, part of your job is to manage and be an advocate for the horse. Be aware of any response you see from the horse, and when the client is able to handle it, point out the impact of the escalation on the horse. Step in to be sure the horse will be safe. Be extremely firm about any violence against anyone, horse included.

**Crisis Development Model**

There is a somewhat predictable progression from initial reaction to physical acting out to the calm down phase after an escalation. Acting out can be either verbal or non-verbal. Verbal acting out requires a verbal response. Physical acting out requires a larger, more physical response. Generally the sending staff or parent would take care of this.

1. **Anxiety Level**—This would be a change in normal behavior, a non-directed built up energy. Your response would be empathy, active listening. Avoid judgment. Most potentially explosive situations are defused here.

   **Non-verbal behavior is very important at this phase.**

   Your nonverbal behavior becomes critical (85-90% of all communication is non-verbal). Someone who is losing rationality will focus on your nonverbal communication more than your verbal.
Consider your

1. Proxemics (personal space)—an invasion can feel threatening. Generally stay at least 1½ to 3 feet away. The need for personal space varies with how large the room is, how we feel that day, and our relationship with the person involved. Verbal and Body language will tell you if you're getting too close. Give as much space as you can and still keep every one safe.

2. Kinesics (body posture and motion). Frontal, face to face, shoulder to shoulder postures are perceived as challenging. A “supportive stance” helps keep every one safer, is non-threatening, and communicates respect.
   • Stand at an angle, one leg a little behind the other, about a leg’s length away.
   • Keep hands visible, at your sides if possible.

3. Para Verbal Communication—the inflection of your voice can vastly change the meaning of a sentence (i.e. “I didn't say you were stupid” means something very different if you put the emphasis on the first word, second or third, on to the end. Try it!). Your tone, volume, and cadence will all convey messages that you may not be aware of.

Monitor the effect of your communication by watching participant feedback and body language. They may not hear what you say in the way you mean it. (“I know you understand what you think I said but I’m not sure you realize that what you heard is not what I meant.” Language is complicated!).

2. Defensive Level—this level involves verbal acting out. The first stage is a loss of rationality, often with verbal belligerence & hostility. He or she may argue about something that has nothing to do with the real problem. The participant will respond to body language, voice tone, etc., more than the words you use. He or she can become verbally abusive, often on a personal level, and may be very good at picking the most sensitive areas you have. It is very easy for the staff member to respond personally at this phase and to slip into his/her own crisis development. I can promise you that your anger or loss of self control here will NOT help. If you find yourself getting angry, it's time to stop the interaction and get someone to take your place.

Verbal Escalation Continuum and Responses:

a. Questioning: They may ask for information in a rude or belligerent way (“Why do I have to do this shit??!!”). They could be seeking information, they could be challenging. Response: Give the information; ignore the challenge; and repeat the direction.

b. Refusal—noncompliance. (“You can't make me do this shit!!”)

c. Response: non-threatening, calm; set limits: Make sure the limits are clear, simple, reasonable, and enforceable. Frame them as a choice with positive options (i.e., your yelling is disturbing your horse and it’s making all the other horses in the class nervous. You can get on and ride if you stop. But you'll have to stay out of the class if you keep yelling. Which do you choose?) It is critical that you remain calm and in control of yourself (rational detachment). This is also where you alert the sending group’s staff, and you may need to turn it over to them.

d. Release—Verbal venting.

e. Response: Allow venting as long as every one is safe. Reduce the audience if you can, even if it means sending the other participants and their horses somewhere else. Remove the horse if that is a safety issue. Restate the choices.

f. Intimidation—threatening behavior, verbal or non-verbal.

g. Response: Remain calm, but call for help.

3. Acting out Level—this usually represents a total loss of self control by the participant. This level can involve physical aggression. Your response is to get help from the sending group’s staff and they may have to do some sort of confinement or restraint. Your job is to keep the others (and the horses) safe. It may mean taking every one else out of the ring. It may also mean getting the client off the horse somehow. (The horse may take care of this for you, or the horse’s response may bring the client back to reality very quickly). It is critical for you to remain calm. Protect your own safety defensively. Protect the other participants and the horse. If restraint is required, be sure it's done by someone who has been trained, and make sure that person can physically handle it (i.e., I've been trained in restraint but I avoid them because of my physical condition).
4. **Tension Reduction**—after the acting out, the person “comes down” and is generally very tired, physically and emotionally. This is the beginning of regaining control. Fear, confusion and remorse are typical reactions. The appropriate response is therapeutic rapport or communication. This will probably be handled by the sending staff. It is the best time to talk about what was going on. Encourage him to take a couple of deep breaths and physically relax. Compliance will help him relax and show that he’s regaining self control. Figure out what happened, and what caused the huge reaction. Once the participant demonstrates self control, it may be a good time for him/her to reconnect with the horse, particularly if the escalation involved any kind of hitting, etc. (Use your common sense about whether this is a good idea!) Encourage an apology. You can also “translate” for the horse about how it felt to be hit or yelled at. Appreciate the client’s sorrow and sense of guilt at having hurt the horse as being appropriate. Help them realize that they made a mistake, that we all make mistakes, and that it’s important that we learn from our mistakes and move on. Do not say that what happened was OK. It wasn’t, but it was forgivable. Offer forgiveness on behalf of the horse. Reconnection and re-establishment of the relationship (before the client leaves if possible) is very important. Keep the sending staff right there in case of a re-escalation.

Be sure to do some kind or contract or agreement around acting out behavior and the consequence for it. The consequence should be related to what was done, repair any damage (material and personal) as much as possible, and assure safety in the future. It is important for you to be empathetic about a reaction to the consequence (“yes, I can see how it will be REALLY hard to apologize to your classmate and your horse, but it’s important for you to do so. Maybe we can figure out what you could say now.”)

If you have had a student who has acted out at the barn, you may need to re-assess how it went and whether your program can handle the participant. Figure out what triggered the reaction, if that trigger can be removed or not, or if a redesign will help take care of the problem. Was there a sensory issue that can be removed? Was it a trauma response? Consider your staff and group responses. If the situation remained safe, and every one acted in helpful ways, you may be able to deal with future acting out. If not, and the problem is unsolvable, then you may want to terminate the activities with the participant.

If you decide to terminate activities, find a kind way to frame it, or have someone who the student trusts help explain why it won’t work out for now. Don’t close the door forever, but describe the reasons you can’t keep the situation safe at this point. And since your job is to keep every one safe, you just can’t have that happen again. When talking with a student about why they can’t take part, don’t blame the participant; blame the fact that the situation isn’t safe.

**Things to remember:**

1. Generally you are not responsible for the precipitating factors that occurred before the participant came to the barn.
2. You are responsible for your response to the student. **Rational detachment is crucial.** Take care of yourself to avoid becoming a precipitating factor. Be aware of your own “buttons” or vulnerabilities and keep them “covered”.
3. Integrated experience: All behaviors have a cause and effect; be aware of your influence at all times.

In conclusion, working with participants who have acting out behavior can be very challenging, but it can also be extraordinarily rewarding, as students begin to learn how to control the behavior that has gotten in their way in many situations. Horses can be a big help in inspiring a person to tune into their own escalation patterns and learn to do the things for themselves that help them remain in control. Providing a situation where that self awareness and learning can take place is a wonderful gift to someone who has severe self control problems. But it must only be given with consideration as to whether you can keep the situation safe. This safety assessment has to take place in the planning phases before the participants come, at every moment when they are there, and after they have left your barn. It’s critically important that you be aware of what your program, your horses, your staff and you can handle.
References:


Various helping methods, including individual, family, and group approaches, have been employed over the years in working with children in the foster care system (Webb, 2003). In the past 25 years, a growing body of evidence has emerged that demonstrates how psychotherapeutic work within the human–animal bond can uniquely benefit children. Anecdotal vignettes, clinical examples, some doctoral dissertations, and a few research studies have documented the effectiveness of this developing field. Although humans and animals have coexisted for centuries, we have barely begun to explore the myriad benefits of the human–animal interaction. Some of the pioneers who saw the value of bringing people and animals together recognized that animals seemed to provide avenues for building empathy, rapport, feelings of acceptance, nurturing abilities, mental stimulation, touch, socialization and stress reduction (Levinson, 1997; Corson, Corson, & Gwynne, 1975; Ross, 1989a, 1989b; Lee, 1984; Katcher, Friedman, Lynch, & Messent, 1980).

Boris Levinson, a clinical psychologist, is considered to be the father of animal-assisted psychotherapy (see Levinson, 1997). When he discovered by accident with his dog, Jingles, the efficacy of this work, he saw the great diagnostic potential associated with working with animals. As the story goes, Levinson was writing in his office one afternoon, about 2 hours before he was to consult with a mother and her young son, when his office doorbell rang. The mother, quite anxious regarding this consult, had arrived early, confused over the time. In the referral information, the child had been reported as “unrelated” and possibly needing hospitalization. When the child saw Jingles lying under the desk as Levinson was writing, he immediately went down on all fours to be with the dog. The mother wanted the session to begin, and she attempted to yank the child up to sit in a chair and talk to the doctor, but Levinson stopped her. They both watched as the child began to relate to the dog. Levinson agreed to accept the referral, based on the information he obtained from observing the child with Jingles. Jingles’ career as a “therapy dog” had begun, together with the field of animal-assisted psychotherapy.

**Animals as Teachers: Helping Children Learn Relationships**

Today, the incorporation of animals into the healing of people is a burgeoning field. “Animal-Assisted Therapy” (AAT) is generally viewed as an umbrella term that includes both “Animal-Assisted Activities” (AAAs) and “Animal-Assisted Therapy” (AAT) in its traditional meaning. **Animal-Assisted Activities.** The Delta Society, (www.deltasociety.org), a “leading international resource for the human–animal bond” whose mission is “improving human health through service and therapy animals,” defines AAA as follows: “AAA[s] provide opportunities for motivational, educational, recreational, and/or therapeutic benefits to enhance quality of life. AAA[s] are delivered in a variety of environments by specially trained professionals, paraprofessionals, and/or volunteers, in association with animals that meet specific criteria.” (These and the following quotes are all from the [www.deltasociety.org](http://www.deltasociety.org) website.) According to this definition – and this is an important distinction – AAAs are basically the casual “meet and greet” interactions that involve pets visiting people. The same activity can be repeated with many people, unlike a therapy program that is tailored to a particular person or medical condition. An example of an AAA would be visiting elderly persons in a nursing home, making the rounds of each ward, with a dog. Benefits that can occur during a visit of a dog, cat, or rabbit include recollection of past memories while petting the animal, subsequent reinvestment in life, and improved motivation.

**Animal Assisted Therapy.** 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. AAT is directed and/or delivered by a health/human service professional with specialized expertise, and within the scope of practice of his/her profession. AAT is designed to promote improvement in human, physical, social emotional, and/or cognitive functioning . . . AAT is provided in a variety of settings and may be group or individual in nature. This process is documented and evaluated. An example of AAT would be a psychotherapy session where an animal was included in the treatment of a child.

Due to the widespread popularity of horses, their species-specific characteristics that enhance the work, and, most importantly, the explosion of recent dialogue in the equine world about the therapeutic benefits
of horsemanship, therapeutic work with horses is recognized as a discipline separate from AAT with other animals; it has an independent status and its own terminology. Kruger (see Kruger, Serpell, & Trachtenberg 2004) elaborates:

“Although the Delta Society lists horses as being animals eligible for certification through their PetPartners® program, interventions involving the use of horses typically fall under the jurisdiction of a separate group of agencies. Prominent among these is the North American Riding for the Handicapped Association (PATH Intl.) and its previous sub-section, the Equine Facilitated Mental Health Association (EFMHA), which provided a definition for the term “equine facilitated psychotherapy” (EFP).

PATH Intl. (www.PATH Intl.org) sets standards for working with horses both in general activities (equine-assisted activities), and therapeutically (equine-assisted therapy, equine-facilitated psychotherapy and hippotherapy). Working with animals in a therapeutic milieu, particularly work with equines, requires specialized training and usually the inclusion of an animal handler.

As I discuss in detail later, AAT can involve either a triangular relationship (between animal, client, and clinician) or a diamond-shaped relationship (when a fourth person, an animal handler, also assists in the work). The therapist establishes the boundaries that connect humans and the animal as part of the AAT process. During the session, the therapist as the coordinator of the clinical work takes account of the behavior and personality of the animal as well as of the client.

Current trends in the field of AAT include calls for more extensive critical research, both quantitative and qualitative, to help AAT gain credibility among other mental health professionals. There also continues to be much discussion of the terminology for how we work in the field and what we call what we do. In lieu of the aforementioned AAA/AAT definitions, some professionals have suggested, or are even currently using, terms such as “animal-assisted interventions.” Others define what they do as “animal-assisted psychotherapy” (the term I personally prefer due to its specific clinical reference) or “therapeutic animal-assisted activities.” Unfortunately, these inconsistencies lead to confusion among clients, other professionals, and the public at large. For AAT to be seriously regarded as a viable treatment modality, the language of AAT must become much more standardized. Lastly, although many workshops and college courses are being conducted by professionals who have worked within the human–animal bond for many years, there remains a need for more accredited AAT certificate training programs. Such specialized training is essential, because professionals who are interested in incorporating this treatment modality into their practice require not only knowledge of human behavior, but also an extensive knowledge of animal behavior.

We are all learning every day by working in various aspects of AAT. This is an exciting and challenging time for the field. The debate about these topics adds freshness to the work and creates potential for growth in the children and adults who are served.

Since 1994, I have had the privilege of working at Green Chimneys Children’s Services for at-risk youth, in Brewster, New York. Green Chimneys (www.greenchimneys.org) has been a pioneer in the field of AAT for many years. I function as the clinical psychologist at the Green Chimneys Farm. My role involves creating innovative programs for the 170 children in the center. These children have difficulties being maintained safely either in a traditional classroom setting, at home, or in the community. Many of the children have histories of trauma. In my work with these children, I utilize AAT as an alternate and effective treatment modality.

In this chapter, I focus specifically on clinical sessions in which I work with equines and other animals. These sessions were conducted with at-risk children who have been in the foster care system for several years, who now reside at a residential treatment facility, and who have histories of trauma. Some recent investigations
show that AAT is helpful when used with traumatized children (Ascione, Kaufmann, & Brooks 2000; DePrekel & Welsch, 2000; Moreau, 2001; Brooks, 2001).

Assessment

Assessment is always the first and foremost concern to the therapist who uses AAT as a treatment modality. In the case of AAT, the assessment pertains to both the client and the animal involved. The animal’s temperament, behavior and willingness to work must be thoroughly assessed on a daily basis. With regard to the child, the assessment includes not only a mental status examination, but an evaluation of the child’s past and present responses to animals. Specifically, in addition to the child’s mood, affect and cognitive functioning, both the client’s history with animals and current reactions to them are assessed. Since animals are integrated into almost all our program areas, we need to know details about each child's history in regard to them.

As we walk around with each child outdoors at the farm, we ask him or her specific questions. These include the question of loss through the death of a pet or seeing an animal die. Many children describe painful situations. For example, one child had an experience in which his father, in a drunken rage, threw the family dog down the cellar stairs, and the child listened to the dog howl in pain until it died. Observing the death of an animal or experiencing the loss of a pet may make it difficult for the child to attach to an animal, or this memory may repeatedly trigger unresolved painful feelings.

Another important area to assess involves animal abuse or aggression toward an animal. We ask each child directly whether he or she has ever hurt or killed an animal, or whether he or she has seen another person do so. We assess both what the child says and how the child answers these questions.

Assessing a child’s moral level of development is another aspect of this assessment. This refers to the child’s understanding of “right” and “wrong” behavior regarding the treatment of living creatures. We take note of any differences between the chronological age of the child and the developmental level at which he or she is functioning. If a child were to have an incident of animal aggression, this knowledge would be helpful in assigning consequences for the behavior. Knowing the child’s level of functioning, both morally and cognitively, helps to formulate the appropriate intervention.

We also ask whether a child likes animals, understanding that some children do not. Each child’s preference is honored, and we assess this on a continuing basis. The child will never be forced to participate in extracurricular animal-related activities.

Many children come into placement frightened of animals. For some children, their connection to animals has been through observing cockfighting, or watching others train a dog to be aggressive. Children who come with fear of animals often change and do well in an AAT program. It is gratifying to watch their fearful behavior change into joyfulness, as a result of the therapist’s thoughtful interventions and patience. Both from being with an animal, and in overcoming fearful behavior, the child’s sense of self-efficacy is enhanced.

Assessing how an under nurtured child touches an animal is an excellent diagnostic indicator. I discuss this further in the next section. Due to the importance of assessing a child for AAT, and the space constraints of this chapter, I refer readers who wish more information about this topic to Levinson (1997).

Touch as a Diagnostic Indicator

Touch is a very good diagnostic indicator for children who struggle with issues of neglect or trauma, and for those who are under nurtured. Observing how a child touches an animal gives us information about how the child has been touched, how the child has been nurtured (or not), and whether the child has experienced some form of intimacy. We look at whether the child attempts to build a relationship with an animal, and how the child does this. We look at whether the child holds the animal like an inanimate object or like a living being, and whether this behavior changes over the assessment session (and, if so, how). Does the child talk only to the animal, or only to the assessor, or to neither? Does the child know how to hold an animal? Does the child have good boundaries while holding the animal, neither smothering it nor holding it too far away? Does the child barely notice the animal, due to being overstimulated by everything else going on around him or
her? Is the child afraid? If so, how does the child deal with this fear? Is there a difference between how the child touches an animal and what the child says about touching animals? These are all important questions to be answered while assessing touch. We invite a child to touch many different animals, both small and large, because there is often a difference in the child’s reaction to animals of different sizes and species.

Another key piece of assessing the child is how the animal reacts to the touch. Does the animal move away, act fearful, or pull its head back quickly? Does the animal come to the child or not? All aspects of this engagement are important for the assessment. Animals respond to their sense of a person’s energy, smell, and speed of approach. They are wonderful partners in diagnosing how children relate, particularly when children move too fast or when their actions and words are incongruent. One child, who came with a history of animal aggression, approached one of our mares while walking around the farm. The child reached out to touch her, and the mare pulled back quickly in an unusual response. Although the energy of the child was not abusive in that moment, the animal sensed the child’s underlying aggression. Animals were only objects to this child, to be manipulated and moved, out of his own needs.

There is often a difference in how a child touches different-sized animals, as suggested above, and the assessment data can reflect this. Sometimes a child likes to ride a horse, but is afraid to touch a horse in its stall. Touching a lamb or a goat may give the child an opportunity to lie down with, hug, kiss, and look deeply into the eyes of an animal. Such interactions are healing for the child and can provide much clinical information for the therapist who is treating the child. When a child is assessed in this way, however, safety concerns must be paramount to protect both the child and the animal.

Children who have been under nurtured have a second chance to experience being wanted through touching and hugging large animals who can “hold” them. Many of us have had a big grandmother who, when she pulled us to her and enveloped us in her big hug, allowed us to feel love and security. Animals, in many ways, can provide such a “hug”; they can certainly give under nurtured children a second chance to feel a sense of security and love.

Many children in the foster care system are under chronic stress from years of being moved within the system and from continually facing the consequences of their negative behavior toward others. Touching and holding animals can allow such children to relax and feel less lonely. Katcher, Friedman, Lynch & Messent (1983) conducted a research study on this concept, monitoring subjects’ blood pressure as a measure of tension versus relaxation. They found that a subject’s blood pressure stayed the same or went down while petting a dog, although it stayed the same or went up when the subject was talking to a person. James Lynch (2000), in his book, A Cry Unheard: New Insights into the Medical Consequences of Loneliness, states that loneliness is one of the most deadly problems undermining our physical health. Animals can help children relax and feel less alone.

**Considerations for Conducting Psychotherapy with Animals**

The role and involvement of the animal are essential in conducting animal-assisted psychotherapy in general and equine-facilitated psychotherapy in particular. The animal included in a psychotherapy session is considered a partner in the work and is specially selected and trained by knowledgeable professionals. The animal is not included as an object manipulated for the betterment of the person, but is included into the session as another living being respected and chosen for its nature, behavioral characteristics, or temperament. An uninformed professional, who is working with an animal in the treatment process for the betterment of the child (or adult) and not also for the betterment of the animal, risks stressing the animal (which will also have poor effects on the client). Moreover, such a professional is an inadvertent role-model, teaching the client that “power over” an animal is all right or that animals are here only for the use and enjoyment of people. Safety concerns for both the client and the animal require knowledge of the animal’s limits in any given session. The therapist must understand animal behavior to understand the animal’s limits in any session. I have seen professionals new to working in the human–animal bond excited about this new “tool.” However, the animal is not a tool in this work, but a living being with its own limitations, fears, and gifts. We must, as therapists, employ self-reflection about animals before we begin this work. If we treat animals as expendable, or carry even the subtlest “power over” mentality, our clients will inevitably assume this attitude themselves. For this reason, we must be mindful as therapists about what we unconsciously convey through our verbal and nonverbal behavior about the care of others different from ourselves.
To conduct the most ethical clinical work, we must know enough about animal behavior to be able to see the subtle signs of stress an animal may experience in doing this work. Also important to consider is the ability of the therapist to explain the behavior of the animal to the client. Furthermore, does the animal want to do this work? A thorough knowledge of animal behavior is essential. Not all animals make good therapy animals. A pet dog may be a good companion, but not a good therapy animal. Knowledgeable and specially trained people should evaluate a particular animal to determine whether the animal can be included in a psychotherapy session. Organizations such as the Delta Society, PATH Intl., and the Human–Animal Bond Association of Colorado and its partners are specifically set up to do this type of evaluation.

Including animals in a psychotherapy session must also be planned with regard to the client. Does the client have allergies to animals? Is the client fearful of animals, or does the client even like animals? Does the client have painful memories regarding animals that may emerge in the session, before the client has developed internal resources to handle these? Many psychotherapists consider animals as wonderful “icebreakers” in beginning to build a therapeutic relationship. However, if some clients are inadvertently opened up too soon, this can add a complication to the psychotherapy and interfere with the treatment plan. Similar to including a client’s sibling or parent in a session, adding an animal to a treatment session must be thoroughly discussed and planned far ahead of time and should not be a surprise. At all times, we must use our clinical judgment and work within our theoretical backgrounds, as well as remain mindful of the relationship we have with our clients (including transference or counter transference feelings). Including an animal in a session can change the relationship with the client in either positive or negative ways. The timing of when to include an animal must be thoughtfully considered, since it may be inappropriate at certain times.

The therapist should be clear about the reasons for including an animal into a psychotherapy session and about how to achieve a positive outcome for the animal and the client. The therapist should have training in animal behavior, and in methods for bringing humans and animals together for the benefit of both. The following case example illustrates what can happen when the therapist does not know how to include animals into a psychotherapy session.

Kitty, a 17-year-old, had been in psychodynamic psychotherapy with her male therapist for 1 year prior to entering the foster care system. The therapy appeared to be at a standstill. The therapist had heard that including a dog in a treatment session could assist a client in feeling more open. The therapist thought that perhaps including his dog in a few sessions would assist Kitty in opening up and trusting him more, in order to facilitate her being able to verbalize and explore more intimate and intense material about the abuse she had suffered at her father’s hands when she was younger.

The therapist brought in his dog, but over the next 2 months Kitty managed to deflect her issues to an even greater degree. In fact, she actually used the dog as a way to avoid opening up even more; she did this by constantly focusing on the dog and its behavior. Rather than focus on her own issues, and what was generated within her from being with the animal, she merely played with the dog without reflection. The therapist was aware of his own counter transference issues coming up as Kitty poured all her affection into his dog. He felt pushed out. The therapist saw what was happening and approached the client with his thoughts, causing Kitty to shut down even more. They discussed having the dog in the sessions and agreed to have the dog stop coming. Shortly after this, Kitty said she did not want to continue treatment. A well-meaning attempt to help a client with a new “tool” boomeranged. A more informed decision, made after the therapist received training in AAT, could have had a different therapeutic outcome.
Two Models for Including Animals in Clinical Sessions

Over the years at Green Chimneys, two models have emerged in the process of conducting AAT. The “triangle model” (Figure 11.1) developed from working independently with an animal and a child. The “diamond model” (Figure 11.2) evolved from my work with an animal handler, and further emerged from a discussion with my colleague Leslie Moreau, MSW. These models have become useful in teaching others how to think about including animals in a clinical session, in psychotherapy, physical therapy, occupational therapy, or recreation therapy. These models serve as ways to facilitate animals in a therapy session within a professional framework.

Figure 11.1. The Triangle Model.
Dr. Susan M. Brooks

Figure 11.2. The Diamond Model:
The triangle and diamond models depict the potential of each participant in a session to ultimately enhance or hinder the connection between the child and animal. Each part of the model influences the others. Clinical work with children and animals focuses on the interaction of all aspects of these models.
One aspect of either the triangle or the diamond model considers what the therapist brings to the relationship at any given moment. The therapist’s response can enhance or hinder the connection the child is making with the animal, as well as the animal’s own behavior. Is the therapist only present physically, while worrying about other things? Animals, like children who carry a chronic trauma history, are attuned to and respond to incongruent behavior. In particular, equines will pick up and be affected by this discrepancy between intent and behavior.

Another aspect of both these models considers what the animal brings at any given moment that can be interpreted to the child for his or her own growth and development. It is impossible to work clinically in this field without having a keen knowledge of animal behavior and being an on-going student of animal behavior. The essence of this work necessitates that the therapist knows how to feed back the animal behavior to the child, so that the child can learn about how his or her own behavior affects others.

The third aspect of both these models is what the child brings that can be shared with the child vis-à-vis the animal’s reaction, to enhance the child’s knowledge about him- or herself. We must understand the behavior of the child and have an understanding of what underlies this behavior.

In the diamond model (Figure 11.2), the animal handler’s energy and presence can also influence the session, in positive or negative ways.

Considerations in using these models in psychotherapy include the following:
1. Knowledge of how to build a therapeutic relationship with animal and client.
2. Self-examination regarding the therapeutic process and what the therapist may unconsciously bring to it.
3. Concerns about the client’s energy or behavior and how that might affect the behavior of the animal.
4. Concerns about the behavior of the animal and how this might affect the behavior or feelings of the client.
5. Factors related to the animal handler (Figure 11.2): What does this person need to know to assist in keeping the session therapeutic?

These issues are dynamic and interactive. An example using the diamond model is as follows:

In an equine-facilitated psychotherapy session, a child on a horse becomes frightened and the horse balks or stops. There may be a wealth of reasons why the horse balks. Either the therapist’s body language or that of the animal handler may be at odds with the therapist’s verbalization. This may cause the child with a trauma history to feel fearful on the horse, because he or she may not know what to respond to – the therapist’s (or handler’s) body language, or the therapist’s words. The child, feeling fear, may cause the horse to balk or stop. In other words, incongruent behavior in the human helpers can cause the child to be fearful, and the child’s fear response may be communicated to the animal:

In addition, what is the role of the equine (let’s assume it’s a male) in ensuring his own safety and well-being, and therefore the well-being of all? Let’s continue the example above by saying that the horse balks, flattens his ears, swishes his tail, and tries to bite the handler. Was the horse asked to participate in too many sessions recently? Was the horse reacting in this manner because he was bored with walking around and around the indoor ring? Or has the animal handler been pulling too heavily down on the lead rope, causing the horse to walk with his head too low? Or perhaps the horse has felt the child’s fear and stopped moving. At any given moment, the dynamics will shift back and forth among all the participants in the session. The therapist should reconsider the important questions mentioned above throughout each stage of the session. Is the therapist’s body language congruent with what is being said? Does the therapist’s body language generate confidence or fearfulness in the traumatized child?

Each aspect of these models can affect the other. Animal-assisted psychotherapy is present-centered work for the therapist. Attending to both the subtlest and the most overt aspects of animal and child communication gives the therapist the knowledge needed to assist the child in making a change in his or her behavior.
Bessel van der Kolk (see van der Kolk, McFarlene, & Weisaeth, 1996) has stated that some people who have been chronically traumatized have had to relearn how to engage in authentic relationships. Some people who have not dealt with their own past trauma issues can be hypervigilant to the subtle nuances of another in terms of their personal safety. Relearning safety cues, and learning to decrease responding from fear in an interaction through affect modulation, are aspects of learning how to be in a relationship and truly meet another. These are skills that can be directly addressed in clinical human–animal interactions.

**Case Examples**

The first clinical vignette is an example of how animal-assisted psychotherapy can be useful in helping children relearn safety cues and affect modulation. In this case, Sam needed to understand the behavior of the animal and to respond directly to that behavior. The behavior of therapy animals is usually untainted by humans' meaning making. Animals do not carry ulterior motives. What you see is what you get, once you learn the behavior of that species and the behavioral nuances of particular individuals. When children learn how to relate to an animal, they can transfer this knowledge to human relationships. Trust and confidence develop as children learn to relate to the animal's behavior. When an animal does not respond to a child, the therapist helps the child to see immediately how his or her behavior contributed to the animal’s response. This is valuable knowledge. It can be fed back to the child and discussed in terms of problems he or she is having relationally with others. The child learns the reciprocity of being in a relationship. After learning and practicing with animal behavior in each session, parallels are drawn back to the humans in the child's life and how the child is relating to them.

**Fear of Rejection: Case of Sam, Age 13**

The case example below illustrates the issue of assisting children with trauma histories to relearn safety cues and to modulate their affect.

**Background**

This clinical example presents an animal-assisted psychotherapy session with a 13-year-old youth I worked with for 1 1/2 years while he was at a residential treatment center. He had grown up in a family of violence. He had watched repeated episodes when his father kicked and hit his mother. His two older sisters, victims of child sexual abuse from their father, had run away from the home. Sam might have been sexually abused by the father as well.

Sam appeared as a smart, sensitive young man who covered his vulnerabilities with constant swearing, spitting, and gang slang. He had a swagger when he walked. Sam anticipated rejection and had built up a rough façade of indifference and arrogant imperviousness, using scorn as a defense. This was manifested in comments and attitudes such as, “He had the nerve to walk away from me,” whether Sam was referring to an animal or a person. Sam did not trust anyone. He covered his anxieties with this rough exterior, and because of this he had difficulties making friends and pushed most people away with his constant swearing. His whole modus operandi was protecting his sensitivities so that no one could see how desperate and fearful he actually was. Sam had been involved in AAAs at the farm for a year, mostly doing chores at the wildlife center and in the horse barn. His behavior worsened after his stepmother refused to take him home. He was then referred for animal-assisted psychotherapy.

**First Session with an Animal**

Below, I describe our first session working with an animal, and our fourth session in Sam's treatment. Our first 3 sessions consisted of just “hanging out” at the farm – that is, walking around and looking at all the different animals. I wanted to see whether Sam had any particular feel for any specific animal. I also was evaluating which animals he showed interest in, how he did this, whether or not he attempted to pet any animal, and (if so) what his touch looked like as he attempted to pet the animals. He spent somewhat more time with Raisin, a 1-year-old male llama, because “man, is he weird-looking.” However, overall, Sam did not appear to be particularly interested in any animal, but appeared to enjoy being out of his classroom. I chose to work with an animal and Sam, because animals can teach children about energy, boundaries, how we move our bodies, and the intensity of purpose we bring to others. These are all particular components
of what we naturally bring or do not bring to our relationships with people. Animals can teach this, because they are very sensitive to our energy and how we move around them. If we move too fast or want to touch animals, they often move away from the intensity of the energy we convey. (For readers who may be unfamiliar with llamas, it is worth noting that llamas are particularly responsive to human movements of this sort. They are very independent animals and are generally careful about maintaining their personal space. However, they are also very curious and will usually approach a human who remains calm and unaggressive.) Sam was referred to me for animal-assisted psychotherapy to assist him in beginning to see how his behavior actually pushed people away. His violent verbalizations and his rapid body movements, which stemmed from his fear of rejection, did not elicit behaviors that would bring people close to him. And, of course, he desperately wanted to feel close to someone, and safe. Here now is a present-tense description of our first session with Raisin.

Sam spits on the ground, and as he does the young male llama walks away, keeping a wary eye on the young man who has just spit. Completely oblivious to this movement of the llama walking away, Sam says in a loud, gruff voice, “In this book I’m writing, Cheetaman is evil! He goes after everyone!” This sudden verbalization illustrates to me that for Sam, being in a pasture with an animal is a nonrelated experience. Sam volunteers information to me, someone he already trusts, because of a deep desire to establish a connection. However, because Sam perceives the animals around him as objects more than beings, he ignores them and initiates an unrelated conversation topic. Sam starts wildly swinging around the lead rope he is holding, trying to tell me yet another violent episode from his personal writing project. The llama stands in the corner of the paddock, and inches his way to the part of the fence that separates him from the male alpaca, which stands on his own side of the fence. They touch noses. Sam is completely unaware of the llama, and of the impact his own actions are having on the animal.

I ask Sam to describe to me what he sees going on in this paddock. Sam looks around and says, “Whatdya mean?” I repeat the question and he looks around, laughs, and says in an exasperated tone, “We’re standin’ in here, and there’s the llama.”

“Yes,” I say. “What might the llama be aware of right now? Do you think he is happy we are in here?”

Sam looks at the llama. Raisin is still near his buddy, the alpaca, but is facing us.

“I don’t know,” Sam says as he begins walking over to the llama, which quickly walks away from him. Sam begins to follow the llama, with his hand outstretched as if he had food or a treat in his hand. Raisin keeps walking away, and Sam begins to chase the llama around the paddock slowly (at a fast walk), attempting to touch it.

“What’s happening now?” I ask.

Sam continues to follow the llama around with one outstretched hand and the other in his pocket. He states, “He won’t let me pet him.”

Sam runs a little at the llama, stops, spits, then slowly swaggerers over to me. He spits again. The llama moves as far away from Sam as he can. Raisin continues to look at his buddy, the alpaca, who is on the other side of the fence. He wants to get closer to the alpaca for protection, but to do so would mean moving closer to Sam. Sam says, “Can we work with another animal? This one doesn’t like me!”

“Why do you think he doesn’t like you?” I ask, attempting to determine whether Sam can see that his own behavior is pushing the llama away.

“Hell, who knows,” says Sam and spits again.

Sam has very few friends. He is unable to see that his behavior actually pushes people away from him. He is obsessed with violent video games and movies. He has also been referred to me because he has experienced some traumatic situations in his home and has been verbally aggressive toward some animals. Sam seems unable to see that the manner in which he expresses himself can actually determine whether people move toward him or away from him. We hope that Raisin’s behavior will teach Sam something about himself.

Sam slumps against the fence, picks up a stalk of hay, and puts it in his mouth, sucking on it.

“You attempt to get closer to the llama, and all he does is walk away,” I say in a slow and calm way.

Sam says nothing and starts to walk toward the llama, again in a fast and purposeful manner, making direct eye contact with the llama. The llama begins to move away quickly, and again Sam begins his slow chase around the paddock. Sam soon gets angry and scares the llama by lifting up his arms.
aggressively and shaking them at the llama, which quickly moves away. The llama stops and looks at Sam. They stand looking at each other, neither moving, facing off. I am ready to intervene when necessary, should Sam’s anger escalate toward the llama. They continue to face off, when Sam’s body begins to relax. Sam looks down, and as he does, Raisin stretches out his neck toward Sam. I say to Sam, “Did you just see what Raisin did?”

Sam spits. Raisin moves away, and Sam says, “Yeah,” in a “So what?” tone of voice.

“He tried to reach toward you a little,” I said. “At first you were pushing him away by your energy. Then what happened?”

Sam spits and says, “I stopped running after him.”

“Yeah that’s right,” I say, “and do you know what you did to let Raisin feel less scared?”

“No,” he says. I role-model what I saw. “When you stopped chasing him, and just stood looking at each other, what were you feeling?” I asked.

“I don’t know,” Sam says. “I wanted to get him to let me touch him.”

“Yeah,” I say, “I saw that the ‘I want to touch him’ had a lot of ‘aggressive–I want to touch him’ energy, right?”

“Yeah,” he says.

“Then I saw you change that,” I say. “Did you see it yourself, what you did?”

Sam says, “I just stopped running after him. I was tired. It was going nowhere.”

“That’s right,” I say. “What were you feeling, though?” Sam shifts his position and looks at Raisin out of one eye, with his head cocked. Raisin is now nibbling hay a short distance away.

“I wasn’t angry any more. I didn’t care if I touched him or not.”

“So something as small as just letting go of anger in your body, relaxing a little, allowed Raisin to reach out a little to you! Let’s see if Raisin would let you touch him or get close if you were more relaxed and didn’t have that ‘aggressive–I want to touch you’ energy.”

Sam spits and acts as if he is bored.

“Try not to make eye contact, and see if you can approach him relaxed and at an angle toward his withers [the high point of the animal’s back],” I say.

Sam starts to walk slowly to Raisin. Raisin stops eating and looks up. Sam continues to walk toward Raisin, approaching near his withers, and Raisin begins to walk slowly away.

“What is Raisin’s behavior telling you now?” I ask.

“He still doesn’t like me,” Sam says.

“How do you know that?” I ask.

“Because he walks away still.”

“OK,” I say. “Good read of the behavior. He does walk away. Could it be Raisin might be feeling something else besides not liking you? What did his behavior tell you? Think about how you were walking toward him for most of this hour.”

Sam says, “Maybe I scared him?”

“Yeah, could be,” I say.

Sam seems to become a little interested, challenged maybe. He is beginning to see that he has some control over how the llama behaves around him. Sam again tries to walk toward Raisin, who is again nibbling at a pile of hay in the corner of the paddock. Sam walks very slowly, almost nonchalantly toward the back of the llama, not making eye contact. Raisin looks up, and Sam stops walking.

“Why’d you stop, Sam?”

“I thought it might scare him if I kept walking,” Sam replies.

“Good for you!” I say. “Good read on what Raisin might feel or need from you.”

Sam has not spit on the ground for at least 15 minutes. Raisin keeps looking at Sam as Sam approaches slowly. Sam stops and just stands there, looking more relaxed. He begins to talk to Raisin like you might talk to your dog.

“Good boy, Raisin!” he says. “Come on, boy, come on.” Raisin just stands by his hay. Sam stops about 3 feet before Raisin, who has not moved away, or eaten any more food. Sam looks up slowly, and Raisin slowly reaches out his neck to sniff Sam. I see Sam become excited, and he quickly reaches to pet Raisin. Raisin quickly moves his head away, but does not run away.

“Aww!” Sam stomps over to me. “See, it doesn’t work! Stupid llama, who cares about this stupid llama anyway!” Sam spits and comes over to me. “Come on, let’s get out of here. I want to go pet
“What did you see happen?” I ask. “You did great!”
“Stupid llama wouldn’t let me touch him . . . who cares anyway?”
“You do!” I say. “Did he run away from you?”
“No, but he’s playing with me, making me look like a fool.”
“I saw him feel more comfortable with you. Up until the end, you were doing great,” I say. Sam spits.
“He’s playin’ with my head,” he says. “He lets me come close and then won’t let me touch him.”
“Llamas can’t play with your head,” I say. “But their behavior can teach us something about ourselves
if we really listen to it and understand it. You did great right up to the end. What happened at the
end?”
“I thought I could just pet him,” he says.
“Yeah, and in the intense energy of ‘I want to touch him now,’ what happened?”
“He moved away.”
“That’s right. Try it again, and at the end keep the same slow energy you had prior to just touching him.”
Sam spits and eyes Raisin, who is eating again – a signal of less stress. Sam slowly walks over to Raisin.
He walks at an angle toward the llama’s withers without making eye contact. Raisin looks up. Sam
stops. Sam then begins to walk very slowly to Raisin. Raisin lifts his head and lets Sam touch the tip
of his nose. Raisin sniffs his hand. Sam just stands there with his hand out. Raisin sniffs again and
puts his head down to eat more hay, still looking up at Sam while he chews. Sam slowly backs away
and then grins at me.

“Hey! Good work!” I say. “What made it work this time?” I ask.
Sam looks down and says, “I didn’t try to scare him.”
“Yup,” I say, “but what behavior did you have that wasn’t scary?”
“I was slow, I didn’t make eye contact. I know that’s aggressive!” he says.
“Raisin wanted to reach out to you then,” I said.
“Yeah . . .”
“Sam, with other kids your age, do you think you come on too strong?” I ask.
“Ya mean, do I try too hard?” he says.
“Yeah. What makes it hard for you to make friends? What might you be doing that pushes people away,
like it did Raisin in the beginning?”
“I don’t know,” Sam says. “Maybe I scare them, too.”
“How might you do that? What happened with Tom the other day?” I ask.
Sam thinks. “Tom thought I was going to hit him ‘cause I was mad at something.”
“Yeah, that’s right. I bet if you could deal with your anger better, you wouldn’t have kids push you away
all the time. Do you see how, when you changed your behavior with Raisin, he let you touch him?
If you can be less aggressive to your peers, I bet they wouldn’t exclude you so much. Why don’t
you try it?”
Sam and I have continued to work with Raisin. Sam has begun to learn llama behavior and to see what
aspects of his human behavior make Raisin come close or move away from him. In working with the
llama over time, Sam is becoming able to translate what he is learning about his own behavior back
into his peer relationships.

Discussion
From this clinical example, we can see that Sam appears as a narcissistically injured young man whose adolescent
ego-centered ways of being were intensified by his deep fear of rejection. Through these psychotherapy
sessions, he could slowly, over time, begin to understand how he could more easily get his needs met
interpersonally. His bravado, as an interpersonal protection, could slowly lessen, and he could begin to make
more direct eye contact with me. Through the immediate feedback from the llama’s behavior, he could see
what it was he was doing that pushed the llama away – and then, as we translated this behavior back to his
relationships with people, could see what he did to push his peers away.

A critical point for Sam was when he became a little engaged in the session. This can be a crucial moment
for children when they start to see that, in fact, they do have control over themselves and how the animal
responds. The point is crucial: The children have to learn that this control is control of themselves and not
control over the animal. This is a vital piece of the therapy. Otherwise, for a child who holds anger as Sam did, it can be translated to ‘power over’ an animal as the only way to have control. For this reason, having well-established clinical skills is vital – as is conceptually understanding animals as living, breathing beings, and not tools in treatment for the betterment of children.

**Building Resilience: Case of Susanna, Age 6**

In this second case, an example of mounted equine-facilitated psychotherapy according to the diamond model is presented.

**Background**

Susanna was referred to equine-facilitated psychotherapy to assist her in building a sense of self. She was quite limited cognitively as indicated by the Wechsler Intelligence Scale for Children – Revised; her Full Scale IQ was 69 at the age of 6 years. Her referral to equine-facilitated psychotherapy stated that she had difficulty with attachment. She had witnessed violence in her biological family before being removed from the home. She was also emotionally and physically abused in foster care. She regressed easily secondarily to becoming overwhelmed. She did not feel safe.

When Susanna was referred to me, she was acting out most of her feelings. This can be associated with not having a sense of self to assist in mediating the emotional ups and downs that all of us face throughout a day. She had to be restrained physically almost every day. The hope from her team in referring her was that as part of her team, I could help her begin to develop an internalized sense of self – or at least, given her limited cognitive ability, could help her develop more emotional controls. Susanna’s diagnoses were posttraumatic stress disorder, chronic type, and oppositional defiant disorder.

Selfpsychology, especially Kohut’s work (Kohut, 1977; Kohut & Wolf, 1978), emphasizes the importance of self-objects in development. I rely on this theory and employ object relations theory in my clinical work (Winnicott, 1992, 1965/1996, 1971/1996). We all need self-objects to help us build a sense of self. “Mother” is thought to be the first self-object that we utilize as she nourishes, soothes, and mirrors back to us, helping us grow and develop acceptance and trust. Susanna did not have this “mother” mirror in a “good-enough” way, in Winnicott’s terms. In designing a series of clinical sessions, I wanted to create opportunities for her to begin the task of experiencing this “good-enough” mothering.

**The Rationale for Bodywork and the Diamond Model**

Somatic techniques can help to ameliorate traumatic effects such as anxiety and dissociation. In setting up clinical sessions for Susanna, I wanted to include bodywork for the following reasons: She was under nurtured, very cognitively limited, and in need of positive physical holding. In making the decision to include bodywork, I decided to put my hand in the center of Susanna’s back during the session described below, as she sat astride a pony. Mothers hold their infants supporting their backs; this allows the infants to feel secure and emotionally held. I felt that putting the flat of my open hand on Susanna’s back was a way Susanna could take in “good-enough” mothering. Although touching a client during a session may be misunderstood or misused, in this case it felt appropriate. Susanna was beginning to develop an attachment to the animal handler and sidewalker. Together, we hoped to create an environment where Susanna could accept healthy touch and our comments to help build her self-esteem. We attempted to create a therapeutic “holding environment,” in Winnicott’s terms, in order for Susanna to grow and feel nourished.

In choosing to work within the diamond model, I took the behavior of the animal, the conformation of the animal, and the animal handler’s equine expertise into consideration. I chose to work with Breeze, a pony, for several reasons. Susanna liked Breeze. In addition, Susanna was short and young, and Breeze was the correct width for optimal comfort in the sitting position. Yet Breeze was also stocky and strong enough that Susanna could lean forward and relax on his neck, increasing the sensation of being “held” by his size and warmth. We used a bareback pad so Susanna could feel the movement of Breeze more directly as he walked around the indoor ring. The sessions, each lasting 30 minutes from mount to dismount, occurred over a year and a half. The example below is from our 10th session, and our 3rd session working in this way.
A Session with an Equine

As we circled the indoor ring one more time, Susanna’s body relaxed more over the neck of Breeze, the pony. The sun was flooding in, and the smell of sweet hay wafted up to us as I sang a lullaby with the palm of my hand flat down, gently, in the center of Susanna’s back. We circled slowly at a walk, around and around the ring. Breeze seemed to enjoy the peaceful feeling, walking attentively and without stress. Susanna closed her eyes and made a gurgling sound with her mouth as she lay over the neck of the pony. The ESMHL and I made eye contact. Likewise, the sidewalker and I connected above the child on the pony. Nonverbal communication between the humans involved in the session can be an important way to facilitate the child’s focus on the feeling created from the experience of being with her pony. I began to croon to Susanna, much as a mother does while holding her infant. I spoke about how relaxed she seemed, what a beautiful day it was, how relaxed Breeze was while “holding” her, and how happy he was to be spending time with her. As we circled the indoor ring, Susanna’s eyes opened and she smiled in a dreamy way, her body relaxed, moving gently with the movement of Breeze. As the end of our 30 minutes of mounted work approached, I gave her prompts that we would be stopping soon, every 3–4 minutes. I did this to prepare her to come back and be with us, and to have her return slowly from this dreamy, relaxed state. At the end of the session, Susanna was asked to sit up on Breeze. When asked whether there was anything she wanted to say, she smiled shyly. With a prompt, she gave Breeze a hug; then she hugged the ESMHL. Finally, Susanna helped to take the bareback pad off Breeze and helped to walk Breeze out to the pasture to join his buddies.

Discussion

We are still working together. Susanna has moved from needing reminders to reach out and pat Breeze, to spontaneously giving Breeze a hug or offering a carrot. These sessions are also helping to build Susanna’s capacity for empathic responses. Over time, Susanna has been able to internalize these positive self-objects and integrate them into a more balanced sense of self. This is permitting her to gradually build a sense of resilience to manage her daily ups and downs.

In this clinical example, the diamond model was utilized, because it was important to have an ESMHL assist in this session. Each person working in this type of session can enhance or hinder the work. While a psychotherapist is leading the session, he or she has to be aware of what each person is bringing to the work, including proper boundaries, energy, and attitude. In this case, communication, especially nonverbal communication, was essential to ensure safety and comfort for all participants in the session, in order to provide what Winnicott would call a safe “holding environment” for the client.

Summary

These foregoing clinical case examples of children with severe traumatic issues demonstrate clinical work in an animal-assisted psychotherapy session and an equine-facilitated psychotherapy session. The models presented offer a theory of how to assist in building a relationship with a person and an animal.

In these types of clinical sessions, knowledge about animal behavior is as important as knowledge about the client. The nuances of the interaction between the animal’s behavior and the nature of the child’s responses, create a milieu in which the child’s growth and development can proceed.

Safety is paramount for all concerned in this work, based on a thorough knowledge of the behavior of humans and animals. As with all forms of psychotherapy, this is not a treatment intervention for everyone. A thorough assessment of the child and the animal is essential in order to determine whether this therapy is appropriate and necessary. Furthermore, the therapist must be trained and knowledgeable about the intricate interactions of all involved in this challenging and rewarding work.

If you would like more information on anything regarding this chapter, please contact.
www.greenchimneys.org

Acknowledgement:
The case of Sam is adapted from Brooks (2004). Copyright 2004 by Greenwood Press. Adapted by permission.
References


Mental Health and Learning Programs

In addition to standard volunteer training at traditional PATH Intl. Centers, those volunteers (and staff) who wish to help with EFMH & L sessions need additional training in how to deal appropriately with participants with mental health and learning needs. These volunteers need to be prepared by the human services professional and the ESMHL for the power of the process, the emotional intensity the equines evoke, and the sensitive nature of the issues that many students/clients may be dealing with in EFL and EFP sessions. Volunteers also should be advised on the need for confidentiality and how to handle their own feelings and issues that may come up during sessions.

In both EFL and EFP sessions, volunteers, as well as other team members may find themselves “triggered” by something said or done during the sessions. The volunteer may have had a similar experience to the client/student and may have unpleasant and/or unresolved feelings surface during the session. The volunteer must be able to put their own issues aside until after the session is over and then get help in processing what has happened if necessary. It is important for the volunteer to recognize when one of the three mechanisms defined below is occurring and not let it interfere with the session in any way.

Below are the three main mechanisms that can be involved in a volunteer’s reactions during a session: Projection, Transference, and Counter-transference.

**Transference** refers to the passing on, displacing, or “transferring” of an emotion or affective attitude from one person onto another person or object. In particular this term is used to describe a situation when the client in therapy ascribes emotions or attitudes of one’s parents, siblings, or other important people in their lives to the therapist.

**Counter-transference** refers to the therapist’s or other team member’s displacement of affect onto the client. This can be a distorting and disruptive element to the therapeutic process if the therapist becomes emotionally involved, or it can be benign or even productive if the therapist recognizes what is happening and deals with what is happening appropriately.

**Projection** means the act, usually unconscious, of ascribing or attributing to someone else one’s own attitudes, thoughts, feelings, desires or behaviors.

Volunteers also need training in how to recognize and not interrupt the therapeutic or teachable moment during a session. Volunteers may be tempted to do too much for the client/student during a session, or may try to soothe them or protect them from their feelings. The first is called enabling, and the second is called rescuing. Enabling is often seen in traditional therapeutic riding lessons, as well as in EFMH & L sessions when a volunteer feels sorry for a student and tries, with the best of intentions, to help the student with some activity that the student really needs to do on his/her own. Rescuing is usually connected to the volunteer’s attempt to “protect” the client from his/her emotions, not realizing that the mental health professional’s goal may be to help the client experience some difficult feelings as part of the treatment plan.

It is especially important in EFP sessions for volunteers to respect the participants’ privacy and confidentiality and follow the lead from the mental health professional about when to step away to allow one-on-one processing time between the Mental Health Professional and the client. The volunteer may overhear the client disclosing some very disturbing information such as details about past traumas, sexual or physical abuse, grief and loss, etc. It is extremely important for the rest of the team to remain as neutral and non-judgmental as possible and not interrupt the therapeutic moment between the therapist, the horse and the client.
Volunteers may be dealing with victims and/or perpetrators, and both are entitled to our empathy, compassion, and acceptance as human beings in order to facilitate their healing and ability to feel empathy themselves. This does not mean that the volunteers or other staff forgive or condone unacceptable behaviors. Instead, it's important to learn how to separate the core person in treatment from their inappropriate behaviors and actions.

If an EFMH & L program decides to allow volunteers to help with sessions, it can be really helpful as long as those volunteers are adequately prepared. Many volunteers find this type of session to be very rewarding and well worth the extra training. It is important to debrief with your team to be sure everyone is emotionally safe before leaving a session.
General Volunteer Training
From PATH Intl. TRI Instructor Manual

The Importance Of Well Trained Volunteers
a) Volunteers are the backbone of any therapeutic riding program
b) A well-trained volunteer is safe, effective, and enhances the quality of the therapeutic riding program while making the lesson enjoyable.
c) Volunteers fulfill many areas of a program including leaders, sidewalkers, board members, fundraising personnel, special event personnel.
d) Volunteers bring additional benefits to the therapeutic riding program through their outside contacts with regards to volunteers and financial sources.

Organization Of The Volunteer Orientation
a) Introduction and welcome
   • Include: what does your program do, what benefit does it bring to the riders, volunteers and community and a general overview of how it operates, why the organization needs volunteers and general job descriptions
   • Introduce the staff, those conducting the orientation and attendants of the orientation
   • Hand out any educational written materials and forms they may need to fill in to enable them to volunteer
   • Inform the volunteers about the expected time commitments and needs of the program
b) Practical segment in the barn
   • Tour of the facility
   • Include a demonstration of leading, securing the horse safely (quick release method), grooming, tacking and equipment adaptations
c) Practical segment in the riding area
   • Safety procedures in the arena, i.e. spacing and paying attention
   • Include: what to expect in class, how to warm up the horse for class, how to line up correctly, tack check, leading, mounting and dismounting, sidewalk, spotting, the body and logistics of a lesson
d) Role play a class situation
   • Roles of the volunteers to include, leading, sidewalk and spotting
   • Mounting and dismounting in a mock class situation
   • Be informed about emergency and incident procedures
e) Practical segment in the barn
   Untacking, putting the horse away
f) Question and answer period and commitments to the program are made.

Important Points To Remember When Working With Volunteers
• Instructors should provide continuing education for the volunteers.
• Volunteers need to have continuous recognition, provided in such a ways as daily, monthly and annually.
• Volunteer recognition and appreciation can be daily in class, through awards nominations and newsletter publications.
• The objective of the orientation is to get an educated commitment to volunteering in your program, increase volunteer's knowledge about the program, and know volunteer expectations.
• Instructors must assess the volunteers’ skills and assign them to the appropriate tasks, riders and horses.
• Base all decisions on the safety of the riders, volunteers and horses.
• Corrections must be made in a positive manner.
• Continuing education classes are a good idea to improve the skill level of the volunteers.
The Do's And Don’ts Of Volunteer Training

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<tr>
<th>DO</th>
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<tr>
<td>• have them participate actively</td>
<td>• leave them unsupervised</td>
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<tr>
<td>• familiarize them with the paperwork</td>
<td>• allow them to break or bend the rules</td>
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<tr>
<td>• encourage questions</td>
<td>• expect them to be perfect</td>
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<tr>
<td>• encourage their ideas and input</td>
<td>• use them as personal servants</td>
</tr>
<tr>
<td>• teach to the skill and knowledge level of the group</td>
<td>• put them in situations they do not know how to</td>
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<td>• let them know how important they are and that they</td>
<td>handle</td>
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<tr>
<td>have a huge impact on the program</td>
<td>• put them or their horse or rider in danger</td>
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Why Do People Volunteer

- People volunteer for a number of reasons!
- People are looking for opportunities for self growth.
- People are preparing for paid employment (gaining experience and new skills).
- People volunteer to get a sense of accomplishment.
- People network while volunteering.
- People are looking to give back to their communities.
- People volunteering feel needed and want to have fun during their spare time.
- People enjoy working with horses and people with disabilities.
Animal Abuse and Youth Violence

Frank R. Asclone

The past two decades have witnessed a resurgence of interest in the relation between cruelty to animals, or animal abuse, and serious violent behavior, especially among youthful offenders. As an illustration, a recent study by Verhulst (2000) of 12 school shootings in the United States (from Marv Lake, WA, in 1996 to Conyers, GA, in 1999) reported that 5 (45 percent) of the 11 perpetrators had histories of alleged animal abuse. The most well-documented example was the case of Luke Woodham, who, in April before his October 1997 murder of his mother and two schoolmates, tortured and killed his own pet dog (Asclone, 1999).

This Bulletin reports on the psychiatric, psychological, and criminological research linking animal abuse to juvenile- and adult-perpetrated violence. It addresses the challenge of defining animal abuse and examines the difficulty of deriving accurate incidence and prevalence data for this behavior. It also explores the relationships between animal abuse and conduct disorder (CD), analyzes the motives of child and adolescent animal abusers, and considers the contexts that may lead to the emergence of animal abuse as a symptom of psychological disorder. (Although a few studies examine the neurobiological correlates of cruelty to animals—see Lockwood and Asclone, 1998—that topic is beyond the scope of this review.) The importance of including information about animal abuse in assessments of youth at risk of committing interpersonal violence is emphasized throughout, and a list of national organizations with programs related to the link between animal abuse and other violent behavior is also provided.

This Bulletin does not suggest that attending to animal abuse is a panacea for dealing with the challenges of identifying and addressing youth violence. Violent behavior is multidimensional and multidetermined, and its developmental course is still the subject of concerted research investigation (Rollin, 1997). However, it is argued here that animal abuse has received insufficient attention—in fact, it is sometimes explicitly excluded (e.g., Stone and Kelner, 2000)—as one of a number of “red flags,” warning signs, or sentinel behaviors that could help identify youth at risk for perpetrating interpersonal violence (a relation first noted in the psychiatric literature by Pfeil in 1869) and youth who have themselves been victimized.

Defining Animal Abuse

All 50 States have legislation relating to animal abuse. Most States categorize it as a misdemeanor offense, and 30 States also have instituted felony-level statutes for certain forms of cruelty to animals. However, legal definitions of animal abuse, and even the types of animals that are covered by these statutes, differ from State to State (Asclone and Lockwood, 2001; Frasch et al., 1999; LaCroix, 1998). The research literature also fails to yield a consistent definition of animal abuse or cruelty to

A Message From OJJDP

Although legal definitions of animal abuse vary, it is a crime in every State, and many States have enacted laws establishing certain forms of cruelty to animals as felony offenses. The forms of abuse to which animals may be subjected are similar to the forms of abuse children experience, including physical abuse, sexual neglect, and even psychological abuse.

It has been said that violence begets violence, but what do we know about the nature of the relationship between the abuse of animals and aggressive behavior towards human beings?

This Bulletin describes psychiatric, psychological, and criminal research linking animal abuse to violence perpetrated by juveniles and adults.

Particular attention is focused on the prevalence of cruelty to animals by children and adolescents and to the role of animal abuse as a possible symptom of conduct disorder. In addition, the motivations and etiology underlying the maltreatment of animals are thoroughly reviewed.

The abuse of sentient creatures demands our attention. The Bulletin includes recommendations to curb such cruelty, while providing contact information for additional resources concerned with violence perpetrated against animals and people.

It is our hope that the information that this Bulletin offers will contribute to reducing both forms of violence.
animals, however, the following definition captures features common to most attempts to define this behavior: "socially unacceptable behavior that intentionally causes unnecessary pain, suffering, or distress to and/or death of an animal" (Ascone, 1993:228).

This definition excludes practices that may cause harm to animals yet are socially condoned (e.g., legal hunting, certain agricultural and veterinary practices). Because the status of a particular animal may vary from one culture to another, the definition takes into account the social contexts that help determine what is considered animal abuse. For the purposes of this review, the animals that are victims of abuse are most often vertebrates because this is the category of animals to which are attributed the greatest capacity for experiencing and displaying pain and distress.

The forms of abuse to which animals may be subjected are parallel to the forms of child maltreatment. Animals may be physically or sexually abused, may be seriously neglected, and, some might argue, may be psychologically abused.

Prevalence of Cruelty to Animals by Children and Adolescents

Because cruelty to animals is not monitored systematically in national crime reporting systems (Howard Snyder, personal communication, January 22, 2001), researchers must rely on data from studies in developmental psychology and psychopathology to estimate the prevalence of this problem behavior in samples of youth. A number of assessment instruments that address child behavior problems include a question about cruelty to animals. However, "cruelty" is not always explicitly defined for the respondent, so it is difficult to determine the exact behaviors that are being reported.

Using the Achenbach-Conners-Quay Behavior Checklist (ACQ), Achenbach and colleagues (1991) collected parent or guardian reports of problem behaviors for 2,900 boys and girls ages 4 to 16 who had been referred to mental health clinics and a control group of 2,800 boys and girls of the same age. The nonreferred children constituted a representative sample of the U.S. population, based on ethnicity, socioeconomic status, and place of residence (urban/suburban/rural and national region [e.g., Northeast, West]). These children had been screened for the absence of mental health referrals in the past year. The referred children were drawn from 18 mental health clinics across the United States. Most of the referred children were being evaluated for outpatient mental health services. Potential candidates for inclusion in the nonreferred and referred groups were excluded if they were mentally retarded, had a serious physical illness, or had a handicap.

One item on the ACQ asks the respondent whether their child or adolescent has been "cruel to animals" in the past 2 months. Respondents can answer using the following 4-point scale: 0 = never or not at all true (as far as you know), 1 = once in a while or just a little, 2 = quite often or quite a lot, or 3 = very often or very much.

Figure 1 shows the percentage of caregivers for each age group, gender, and referral status, that reported the presence of cruelty to animals (David Jacobsowitz, Statistician Programmer, Achenbach System for Empirical Behavioral Assessment, College of Medicine, University of Vermont, personal communication, July 17, 1992). In their statistical analysis of individual ACQ items, Achenbach and colleagues noted that cruelty to animals was significantly (p<0.01) higher for referred youth, boys, and younger children.

The data in figure 1 illustrate the relatively low frequency of cruelty to animals in the nonreferred sample (0-3 percent) in comparison with the referred sample (7-10 percent). Eighteen to twenty-five percent of referred boys between the ages of 6 and 16 were reported to have been cruel to animals, and the data suggest this item's incidence has greater stability through childhood and adolescence for boys than for girls.

Data on the prevalence of cruelty to animals are also provided in the manuals for the Child Behavior Checklist (CBC), perhaps one of the most widely used checklists for child behavior problems, which is available in separate versions for 2- to 3-year-olds (Achenbach, 1992) and 4- to 18-year-olds (Achenbach, 1991). The cruelty

![Figure 1: Percentage of Youth Reported by Caregivers To Have Been Cruel to Animals, by Offender's Age, Gender, and Referral Status](image)

Note: Data show caregivers' responses to a question asking whether their child or adolescent had been cruel to animals in the past 2 months.

to animals item on the CBC (which uses a "past 2 months" timeframe or 2- to 3-year-olds and a "past 6 months" timeframe for 4- to 18-year-olds) is scored on a 3-point scale: 0 = not true (as far as you know), 1 = somewhat true or sometimes true, or 2 = very true or often true. Referred and non-referred boys and girls can be compared for each of three age groups. These data are presented in figure 2. In this figure, data on acts of vandalism committed by the two older age groups are included for comparison. Again, cruelty to animals is more often reported for younger children and boys, especially those referred for mental health services. Figure 2 also suggests that reported rates of cruelty to animals (for youth ages 4 and older) are higher than or similar to reported rates of vandalism, a problem behavior about which more systematic juvenile crime data are available.

**Limitations of Adult Reports on Children's Cruelty to Animals**

Both the ACO and CBC rely on caretakers' reports, and comparable information from youth's self-reports of cruelty to animals is not available. The reliance on caretakers' reports, however, could be problematic because animal abuse may be performed covertly (a characteristic shared with youth vandalism and firesetting) and caretakers may be unaware of the presence of this behavior in their children. Offord, Boyle, and Racine (1991) surveyed a nonclinical sample of 1,232 Canadian parents/guardians and their 12- to 18-year-old boys and girls. They asked respondents (both parents/guardians and adolescents) to report on a number of CD symptoms, based on a 3-point scale identical to the one used with the CBC. (See pages 4-5 for a more indepth discussion of the link between CD and animal abuse.) Figure 3 compares parent/guardian reports of cruelty to animals with youth self-reports. These data suggest that parents and guardians may seriously underestimate cruelty to animals, with boys self-reporting this behavior at 3.8 times the rate of parents/guardians and girls at 7.6 times the parent/guardian rate. Similar underestimates appear for other CD symptoms, vandalism and firesetting, that may often be covert and, therefore, unknown to or undetected by parents or guardians (see figure 4).

A recent study of a nonclinical sample of youth (1,333 boys and 837 girls; mean age, 14.6 years) in Alexandria, Egypt (Youssef, Atia, and Kamel, 1999), also provides data on self-reported cruelty to animals. Dividing their sample into two groups—one reporting that they had engaged in violent behavior (verbal or physical force that tended to inflict harm or cause bodily injury) and the other reporting that they had not—Youssef, Atia, and Kamel (1999:284) asked youth whether they were ever cruel to animals. Of the violent youth, 9.5 percent reported being cruel; of the nonviolent, 2.05 percent reported being cruel. The cruelty-to-animals variable significantly (p < 0.003) determined membership in the violent or nonviolent group.

It should be noted that instruments used to assess teacher reports of children's problem behaviors rarely include an item on animal abuse (e.g., Reynolds and Kamphaus, 1992). Although teachers are unlikely to observe their pupils being cruel to animals, teachers may hear about such acts or read about them in students' written work. These indirect observations should be taken seriously and serve as a signal for further assessment (Dwyer, Osher, and Wager, 1998).

### Animal Abuse and Violent Offending

Animal abuse and interpersonal violence toward humans share common characteristics: both types of victims are living creatures, have a capacity for experiencing pain and distress, can display physical signs of their pain and distress (with which humans could empathize), and may die as a result of inflicted injuries. Given these commonalities, it is not surprising that early research in this area, much of it using retrospective assessment, examined...
Figure 3: Comparison of Parental Reports and Self-Reports of Cruelty to Animals Among 12- to 16-Year-Olds, by Offender’s Gender

[Chart showing comparison of parental and self-reports of cruelty to animals among boys and girls]


Figure 4: Comparison of Parental Reports and Self-Reports of Vandalism and Firesetting Among 12- to 16-Year-Olds, by Offender’s Gender

[Chart showing comparison of parental and self-reports of vandalism and firesetting among boys and girls]


the relation between childhood histories of animal abuse and later violent offending.

Kellert and Felthouse (1985) found that violent, incarcerated men reported higher rates of “substantial cruelty to animals” in childhood (25 percent) than a comparison group of nonincarcerated men (9 percent). A similar difference emerged in a study of assaultive and nonassaultive women offenders (Felthouse and Yudowitz, 1977): 36 percent of the former group reported cruelty to animals compared with 6 percent of the latter.

Miller and Knutson (1997) examined self-reports of animal abuse by 299 inmates incarcerated for various felony offenses and 308 introductory psychology class undergraduates. The percentages of inmates and undergraduates, respectively, reporting the following types of animal abuse were as follows: “Hurt an animal” 16.4 percent and 9.7 percent, “Killed a stray?” 32.8 percent and 14.3 percent, and “Killed a pet?” 12 percent and 3.2 percent.

More recently, Schiff, Louw, and Ascione (1999) surveyed 117 men incarcerated in a South African prison about their childhood animal abuse. Of the 58 men who had committed crimes of aggression, 53.3 percent admitted to cruelty to animals; of the 59 nonaggressive inmates, the percentage was 10.5 percent.

In a study of 28 convicted, incarcerated sexual homicide perpetrators (all men), Kessler, Burgess, and Douglas (1988) assessed the men’s self-reports of cruelty to animals in childhood and adolescence. Childhood animal abuse was reported by 36 percent of the perpetrators, and 48 percent admitted to abusing animals as adolescents. Thirty-six percent of these men said they had also abused animals in adulthood. In a study by Tingle et al. (1986) of 64 convicted male sex offenders, animal abuse in childhood or adolescence was reported by 48 percent of the rapists and 30 percent of the child molesters.

Taken together, these studies suggest that animal abuse may be characteristic of the developmental histories of between one in four and nearly two in three violent adult offenders.

Animal Abuse and Conduct Disorder

The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) defines CD as “a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated” and requires that at least 3 of 15 separate symptoms be present in the past year for a diagnosis of CD (American Psychiatric Association, 1994b). Among the symptoms listed are those categorized under “deceitfulness or theft,” “destruction of property” (which encompasses firesetting and vandalism), and “aggression to
people and animals" (which includes cruelty to people or to animals, stealing with confrontation of the victim, and forced sexual activity). There is a great deal of overlap between the symptoms of CD and behaviors used to characterize serious violent juvenile offenders (see Loebel, Farrington, and Waschbusch, 1998:14-15). Cruelty to animals has only recently been included in the symptoms list for CD, appearing for the first time in the revised third edition of the Manual (DSM-III-R; American Psychiatric Association, 1987).

Cruelty to animals, however, does not specifically appear in any of the categories (i.e., person, property, drug, and public order) under which juvenile offenders are classified in national crime reporting systems (see Snyder and Sickmund, 1999) despite law enforcement's acknowledgment of the link between animal abuse and human violence (Lockwood and Church, 1996; Ponder and Lockwood, 2003; Schleuter, 1999; Turner, 2000).

Animal abuse may vary in frequency, severity, and chronicity and range from the developmentally immature teasing of animals (e.g., a toddler pulling a kitten along by the tail) to serious animal torture (e.g., stealing neighborhood pets and setting them on fire). Unfortunately, most assessments of cruelty to animals lack a scaling of these important differences. One exception is the Interview for Antisocial Behavior (IAB) developed by Kazdin and Esbern-Dawson (1980). Although it was created before the 1987 revision of the DSM, this instrument assesses 20 forms of antisocial behavior, several of which reflect the current CD symptom listings (established in 1994). The IAB has a number of positive features, including both parent- and self-report forms and ratings of problem severity and chronicity.

As illustrated in a study of psychiatric outpatient referrals by Loebel et al. (1993), patterns of chronic behavior may be more significant than isolated incidents. Three yearly assessments that included questionnaires about cruelty to animals were completed by 177 boys ages 7-12 years, some of whom (40.1 percent) were diagnosed with oppositional defiant disorder (ODD) and others (28.4 percent) with CD. Single-year assessment of cruelty to animals did not differentiate boys with ODD from those with CD, but a significant difference emerged when scores on this item were aggregated over a 3-year period: cruelty to animals was present for 13.3 percent of boys with ODD and 29.4 percent of boys with CD (p<0.05).

Because of the interest in early identification of children at risk for later violent offending, it should be noted that cruelty to animals may be one of the first CD symptoms to appear in young children. Parents' reports on the emergence of CD symptoms in their children mark 4 to 14 years as the median age for onset of "hurting animals"—earlier than bullying, cruelty to people, vandalism, or setting fires (Frick et al., 1995). That study reinforces the importance of considering animal abuse a significant early warning sign for identifying youth with potential for receiving a CD diagnosis. The diagnostic value of this symptom is also supported in a report by Spitzer, Davies, and Barkley (1990), which was based on national field trials for developing DSM-III-R.

Recently, Luk et al. (1999:20) reported a reanalysis of case data for a sample of children (n=141) referred to mental health services for "symptoms suggestive of oppositional defiant/conduct disorder" and control data for a sample of community children (n=37). The clinic-referred children were subdivided into two groups based on CBC assessments: cruelty to animals present (n=49) and absent (n=101). Therefore, 28.4 percent of the clinic-referred children displayed animal abuse. The community children were selected only if cruelty to animals was absent in their CBC assessments. Luk et al. demonstrated that differentiating the clinic-referred subgroups on the basis of cruelty to animals was related to scores on a measure of childhood behavior problems that, unlike the CBC, does not assess cruelty to animals—the Eyberg Child Behavior Inventory (Eyberg and Ross, 1978). The authors found that clinic-referred children assessed as being cruel to animals had significantly (p<0.001) higher mean problem and problems severity scores on the Eyberg Inventory than both clinic children who were not cruel to animals or community children.

Thus, there is substantial evidence for the value of assessing cruelty to animals as a specific symptom of CD and as a correlate of other forms of antisocial behavior in both childhood and adulthood. One additional study will be described to illustrate this conclusion.

Arluke and colleagues (1989) reviewed the files of the Massachusetts Society for the Prevention of Cruelty to Animals and located the records of 353 individuals (140 males and 7 females, age range 11-70 years) who had been prosecuted for intentional physical cruelty to animals (not passive forms of cruelty such as neglect). A comparison group of 153 individuals (matched for age, gender, and socioeconomic status, but with no record of any cruelty-to-animal complaints) was selected from the same neighborhoods in which those who had been prosecuted resided. The State's criminal records were reviewed for each individual in both groups. Any adult arrests for violent, property, drug, or public order offenses were noted. As shown in figure 5, individuals prosecuted for animal abuse were more likely to have an adult arrest in each of the four crime categories than the comparison group members. The differences between percentages for abusers and nonabusers were highly significant (p<0.001) for all four types of offenses. These results make it clear that animal abusers are not only dangerous to their animal victims but also may jeopardize human welfare.

Motivations That May Underlie Animal Abuse by Children and Adolescents

Whenever high-profile cases of animal abuse are reported in the media, a common public reaction is to ask: "Why would someone do that?" Burying puppies alive, shooting wild Mustangs, setting a dog on fire, beating a petting zoo donkey—these and countless other examples offend the public by their seemingly senseless cruelty. In an effort to better understand this phenomenon, Kellert and Felthous (1985: 1122-1124) interviewed abusers and discovered a number of motivations that may characterize adult cruelty to animals, some of which may also be applicable to animal abuse perpetrated by juveniles:

- To control an animal (i.e., animal abuse as discipline or "training").
- To retaliate against an animal.
- To satisfy a precedent against a species or breed (e.g., hatred of cats).
- To express aggression through an animal (i.e., training an animal to attack, using inflicted pain to create a "mean" dog).
- To enhance one's own aggressiveness (e.g., using an animal victim for target practice).
- To shock people for amusement.
- To retaliate against other people (by hurting their pets or abusing animals in their presence).
Figure 5: Percentage of Types of Other Offenses Committed by Individuals Prosecuted for Animal Abuse and a Control Group Who Did Not Abuse Animals

- Violent
- Property
- Drug
- Disorder

Percentage

Animal abusers Nonabusers of animals

<table>
<thead>
<tr>
<th>Type of Other Offense</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violent</td>
<td>10</td>
</tr>
<tr>
<td>Property</td>
<td>5</td>
</tr>
<tr>
<td>Drug</td>
<td>15</td>
</tr>
<tr>
<td>Disorder</td>
<td>20</td>
</tr>
</tbody>
</table>

Note: Age range of sample: 11–76 years. All chi-square comparisons between abusers and nonabusers significant at p<0.0001.


- To displace hostility from a person to an animal (i.e., attacking a vulnerable animal when assaulting the real human target is judged too risky).
- To experience nonspecific sadism (i.e., enjoying the suffering experienced by the animal victim, in and of itself).

Child and adolescent motivations for animal abuse have not been studied as extensively. However, case reports and a youth interview study (using the Cruelty to Animals Assessment Instrument conducted by Asclone, Thompson, and Block 1997) suggest a number of developmentally related motivations:

- Curiosity or exploration (i.e., the animal is injured or killed in the process of being examined, usually by a young or developmentally delayed child).
- Peer pressure (e.g., peers may encourage animal abuse or require it as part of an initiation rite).
- Mood enhancement (e.g., animal abuse is used to relieve boredom or depression).
- Sexual gratification (i.e., bestiality).

- Forced abuse (i.e., the child is coerced into animal abuse by a more powerful individual).
- Attachment to an animal (e.g., the child kills an animal to prevent its torture by another individual).
- Animal phobia (that cause a preemptive attack on a feared animal).
- Identification with the child's abuser (e.g., a victimized child may try to regain a sense of power by victimizing a more vulnerable animal).
- Posttraumatic play (i.e., reenacting violent episodes with an animal victim).
- Initiation (i.e., copying a parent's or other adult's abusive "discipline" of animals).
- Self-injury (i.e., using an animal to inflict injuries on the child's own body).
- Rehearsal for interpersonal violence (i.e., "practicing" violence on stray animals or pets before engaging in violent acts against other people).
- Vehicle for emotional abuse (e.g., injuring a sibling's pet to frighten the sibling).

CD assessments are not usually designed to discover the underlying reasons for a child's or adolescent's cruelty to animals, but as with juvenile firesetting (discussed below), understanding motivations may be critical for designing effective intervention strategies. A recent review by Agnew (1998) provides a more extensive treatment of the social-psychological causes of animal abuse.

As noted by Asclone and Lockwood (2001), one model that could be used to develop an animal abuse assessment instrument is the approach that has been taken to assess juvenile firesetting. Firesetting shares many features with animal abuse: both are CD symptoms, may reflect developmental changes, may share etiological factors, may often be performed covertly, and may be early sentinels for later psychological problems.

Some children may manifest both problem behaviors. Warden and Berkley (1984) noted the co-occurrence of cruelty to animals in a sample of 59 firesetters ages 4–17; cruelty to animals was reported for 46 percent of 4- to 8-year-olds, 9 percent of 9- to 12-year-olds, and 12 percent of 13- to 17-year-olds. The authors caution that the lower rates for older children and adolescents may be related to the covert nature of this behavior, as children experience greater independence and venture farther from home for more prolonged periods. Saltman and Osborn (1994) reported similar results with samples of children who set fires (n=100) and those who did not (n=25). Fifty percent of the firesetters' parents reported that their children had been cruel "to children or animals," but only 9 percent of parents of the children who did not set fires reported the same (p<0.01).

Animal abuse in the context of firesetting may also have predictive value. Rice and Harris (1996) reported on a sample of 243 firesetters who had resided in a maximum-security psychiatric facility and were later released. In a followup of 208 of these men, Rice and Harris found that a childhood history of cruelty to animals (coded from patient records) predicted violent offense recidivism (p<0.001) and nonviolent offense recidivism (p<0.05) but not firesetting recidivism.

The Salt Lake City Area Juvenile Firesetter/Arson Control and Prevention Program (1992), funded by the Office of Juvenile Justice and Delinquency Prevention, is based on a typology of juvenile firesetters that may be relevant for developing a
typology for children who abuse animals (Marcel Chappuis, personal communication, March 23, 1998). The typology of juvenile firesetters categorizes children into the following groups:

- **Normal curiosity firesetters.** The mean age of this group is 5 years (range, 3–7 years). Children in this group often share the characteristics of poor parental supervision, a lack of fire education, and no fear of fire.

- **“Plea-for-help” firesetters.** The mean age of this group is 9 years (range, 7–13 years). The group’s firesetting is often symptomatic of more deep-seated psychological disturbance. The individuals usually have adequate fire education.

- **Delinquent firesetters.** The mean age of this group is 14 years (range, 13 years to adulthood). Firesetting may be one of a host of adolescent-onset antisocial behaviors, including gang-related activities, exhibited by this group.

The Salt Lake City program has developed a series of assessment scales geared to each age group of firesetters that can be administered to the child and the child’s parent/guardian. In addition to questions about fire education and the firesetting incident(s), this series has questions about general behavior problems (similar to items on the CBC), including one item about cruelty to animals. (There is also a direct question about whether the firesetting incident involved the burning of an animal.) Responses to these assessments are used to select an intervention strategy. Children who fall into the normal curiosity group are often enrolled in a fire education program, and attempts may be made to educate parents about fire safety and the need for supervising young children. Children who fall into the other two groups are referred to mental health services because fire departments are not prepared to deal with the psychological problems these young people may present.

It might be possible to develop a similar typology for children who abuse animals. Although there is not a great deal of empirical information on which to rely, the study by Aschone, Thompson, and Black (1997) suggests the varied motivations that may underlie child and adolescent animal abuse. Using the extensive experience of animal control and animal welfare professionals, one could develop a typology mirroring that for juvenile firesetters. A sketch of such a typology might approximate the following:

- **Exploratory/curious animal abuse.** Children in this category are likely to be of preschool or early elementary school age, poorly supervised, and lacking training on the physical care and humane treatment of a variety of animals, especially family pets and/or stray animals and neighborhood wildlife. Humane education interventions (teaching children to be kind, caring, and nurturing toward animals) by parents, childcare providers, and teachers are likely to be sufficient to encourage desistence of animal abuse in these children. Age alone should not be the determining factor in including children in this category. For example, CD symptoms may have an early developmental onset, and as noted earlier, cruelty to animals is one of the earliest CD symptoms to be noted by caretakers. Older children who are developmentally delayed may also fall into this group.

- **Pathological animal abuse.** Children in this category are more likely to be (though not necessarily) older than children in the exploratory/curious group. Rather than indicating a lack of education about the humane treatment of animals, animal abuse by these children may be symptomatic of psychological disturbances of varying severity. For example, a number of studies have tied childhood animal abuse to childhood histories of physical abuse, sexual abuse, and exposure to domestic violence (see pages 8–9 for discussions of these issues). In these cases, professional clinical intervention is warranted.

- **Delinquent animal abuse.** Youth in this category are most likely to be adolescents whose animal abuse may be one of a number of antisocial activities. In some cases, the animal abuse may be a component of gang/cult-related activities (e.g., initiation rites) or less formal group violence and destructiveness. The use of alcohol and other substances may be associated with animal abuse for these youth, and they may require both judicial and clinical interventions.

### The Etiology of Animal Abuse

Although “bad seed” interpretations of youth violence have waxed and waned throughout history (Garbarino, 1999; Kellerman, 1999), it is clear that attention to the family, social, and community contexts of children’s lives is critical for understanding violent behavior. This holds true for the special case of animal abuse. As Widom (1989) has demonstrated, a history of child abuse and neglect places individuals at risk for later delinquency, adult criminal offending, and violent criminal activity. This section addresses factors in children’s lives that have been associated with increased levels of animal abuse. The factors range from negative but relatively normative experiences (corporal punishment) to potentially more devastating circumstances (physical abuse, sexual abuse, and domestic violence).

#### Corporal Punishment

Evidence continues to mount on the ineffectiveness and deleterious nature of corporal punishment as a child-rearing technique (Straus, 1991). Two recent studies link this evidence to animal abuse. In a survey of 267 undergraduates, 60.4 percent...
of whom were women, Flynn (1999a) asked participants about their history of abusing animals (e.g., hurting, torturing, or killing pets or stray animals; sex acts with animals). Students also responded to items assessing attitudes toward spanking and husband-on-wife abuse. In all, 34.5 percent of the men and 33.3 percent of the women reported at least one of these behaviors in the history of animal abuse. These respondents (both men and women) were significantly more likely to endorse the use of corporal punishment and to approve of a husband slapping his wife. Although these findings do not establish a direct link between animal abuse and child abuse, they do suggest an association between animal abuse and accepting attitudes toward these activities.

In a follow-up report with this same sample of undergraduates, Flynn (1999c) found that, for men, perpetrating animal abuse was positively correlated with the frequency of their father's use of corporal punishment (spanking, slapping, or hitting) in adolescence. Self-reports of animal abuse by men experiencing paternal corporal punishment in adolescence were 2.4 times higher than for men who were not physically disciplined (57.1 percent and 23.1 percent, respectively, $p<0.005$).

**Physical Abuse**

Research specifically designed to assess the relation between animal abuse and child maltreatment is meager yet compelling in its implications. For example, a 1993 study by DeViney, Dickert, and Lockwood of 53 New Jersey families that met State criteria for substantiated child abuse and neglect and had pets in their homes revealed that in 50 percent of these families, pets were also abused or neglected. Animal abuse was significantly higher (88 percent) in families where child physical abuse was present than in families where other forms of child maltreatment (e.g., sexual abuse) occurred (34 percent). One or both parents and their children were responsible for abusing the families’ pets.

**Sexual Abuse**

Friedrich et al. (1992) compared a nonabused sample of 880 children ages 2–12 with 276 children in the same age range who had been sexually abused in the past 12 months. Based on a reexamination of data from this study, Friedrich (personal communication, April 1992) provided information on cruelty to animals derived from the nonabusing caretakers’ CBCS reports on children. As shown in figure 6, children with a history of sexual abuse were significantly ($p<0.001$) more likely to have been cruel to animals than children in the nonabused group. A study of 499 seriously mentally ill 5- to 18-year-olds hospitalized at a tertiary care psychiatric facility (McClellan et al., 1985) also found cruelty to animals to be more prevalent among patients who had been sexually abused than among those who had not been sexually abused ($p=0.004$).

One form of cruelty to animals that has received scant attention in the literature is the sexual abuse of animals, or bestiality. Bestiality may range from touching or fondling the genitalia of animals to sexual intercourse and violent sexual abuse. Some species of animals may be seriously injured or die as a result of the abuse inflicted (e.g., penetration that damages internal organs). Ehrich (1987) provided an excellent theoretical overview of this issue, but empirical studies, especially with children, are rare (e.g., see case study by Wieand, Schmidt, and Kiefer, 1999). Lane (1997) noted that juvenile sex offending may include bestiality, sometimes combined with other violent behavior toward animals. Adolescent sexual offenders may also use threats of harm to pets as a way of gaining compliance from their human victims (Kaufman, Hilliker, and Daleiden, 1996). In the study of sexual homicide perpetrators cited earlier (Russo, Burgese, and Douglas, 1988), 40 percent of the men who said they had been sexually abused in childhood or adolescence reported having sexual contact with animals. Itzhak (1998) reported anecdotal evidence of bestiality being forced on children who also were sexually abused and involved in the production of child pornography.

Although it is difficult to obtain information about sexual behavior in children and adolescents, especially sexual behavior with animals, Friedrich (1997) provided some information on this issue with data from his Child Sexual Behavior Inventory (CSBI). Caregivers of 1,114 children ages 2–12 who had not been abused and caregivers of 512 sexually abused children in the same age range reported on the variety of sexual or sexualized behaviors in the children, including whether the child “触及s animals’ sex parts.” (Note: The reporting caregivers of the sexually abused children were not the perpetrators of the abuse.) The children were divided into three age groups: ages 2–5, 6–9, and 10–12. The queried behavior was relatively infrequent, but it was clear that in the two older groups, sexually abused children were more likely to display the behavior than nonabused children (see figure 7). Although the behavior appears to decline among sexually abused 10- to 12-year-olds, one might speculate that the decrease is accounted for, in part, by a greater secretiveness in older children in acting out sexually with animals. The decrease may also be related to older children’s transferring their inappropriate sexual activity from animal to human victims.

Further evidence for the relation between sexual abuse victimization and bestiality is

![Figure 6: Percentage of Youth Ages 2–12 Reported by Caregivers To Have Been Cruel to Animals, by Offender’s Gender and History of Sexual Abuse](source: Friedrich, W.N., personal communication, April 1992.)
Figure 7: Percentage of Youth Ages 2-12 Reported by Caregivers To Have Sexually Abused Animals, by Offender’s Age, Gender, and Victimization Status


Figure 8: Percentage of Women Who Reported That Their Domestic Partners Hurt or Killed Pets, by Reporter’s History of Domestic Abuse


provided by Wherry and colleagues (1995). They administered the CSBI to caregivers of 24 boys ages 6–12 who were psychiatric inpatients. Eight of these boys had been sexually abused. “Touches animals’ sex parts” was reported for 50 percent of abused boys but none of nonabused boys (p=0.01).

**Domestic Violence**

Animals may also be abused in the context of family violence between intimate adult partners. Ascione (1998) reported an interview study of 38 women who were battered and had sought shelter. Fifty-eight percent of the women had children and 74 percent had pets. When asked whether their adult partner had ever threatened or actually hurt or killed one or more of their pets, 71 percent of women with pets responded “yes.” Thirty-two percent of women with children reported that their children had hurt or killed one or more family pets. In a replication study of 100 women who were battered and had entered a shelter and a comparison group of 117 nonbattered women, all of whom had pets, Ascione (2000b) found that 54 percent of the battered women compared with 5 percent of the nonbattered women reported that their partner had hurt or killed pets (see figure 8). Children’s exposure to this animal abuse was reported by 62 percent of the battered women. Nearly one in four of the battered women reported that concern for their pets’ welfare had prevented them from seeking shelter sooner.

Flynn (2000) reported similar findings in a study of 43 women with pets who had entered a South Carolina domestic violence shelter. (Twenty-eight of the women were accompanied by children.) Of these 43 women, 46.5 percent reported threats to (n=9) or harm of (n=11) their pets. Although only 7 percent of children were reported to be cruel to animals, 33.3 percent of women whose pets were abused reported that their children had also been abused. Of the women whose pets were not abused, 15.8 percent reported child abuse. (The figure was 10.5 percent for women with no pets.)

These studies make it clear that in families challenged by child maltreatment and domestic violence, there is increased opportunity for children to be exposed to the abuse of animals. Even if adult family members do not abuse animals, some children may express the pain of their own victimization by abusing vulnerable family pets. Just as researchers are beginning to understand the overlap between child abuse and neglect and domestic violence between intimate adult partners (Ross, 1999), they must now consider the overlap of these forms of abuse with animal maltreatment (see figure 9).

**Policy Implications and Recommendations**

This section addresses issues relating to the reporting, assessment, and treatment of children involved in animal abuse. It presents recommendations associated with these issues and highlights the need for enhanced professional training.
Reporting

Cruelty to animals is all too often a part of the landscape of violence in which youth participate and to which they are exposed. The number of animals that are victims of such abuse is, at present, difficult to estimate, as is the number of young people who perpetrate such abuse. In an ideal world, national data would be available on the yearly incidence of animal abuse, data that could be used to track trends and serve as a baseline against which the effectiveness of interventions could be assessed. The existing national data collection systems in the area of child abuse and neglect illustrate the value of such archival records (Sedlak and Broderick, 1996). However, it is not clear how animal abuse offenses could be incorporated into the existing categorization (person, property, drug, public order) of juvenile arrests.

Only two states (Minnesota and West Virginia) mandate that veterinarians report suspected cases of animal abuse (Pfasch et al., 1999). Until a national system of monitoring and reporting animal abuse is instituted, the following approaches to recording cases of animal abuse are recommended:

- Local humane societies, societies for the prevention of cruelty to animals, and animal control agencies should routinely refer cases of serious, juvenile- and adult-perpetrated animal abuse to social welfare and law enforcement agencies and should maintain systematic records that could be available for archival review (Assalone and Bomard, 1998; Assalone, Kaufmann, and Brookes, 2000).

- Parents, childcare providers, teachers, others who play caregiving roles for children (e.g., clergy, coaches), and young people themselves should be informed that animal abuse may be a significant sign of a tendency to violence and psychological disturbance and should not be ignored. Efforts in this area are already emerging and include Early Warning, Timely Response: A Guide to Safe Schools (Osher, Osher, and Wargter, 1998) from the U.S. Department of Education and the Warning Signs guide (1999) developed by MTV Music Television and the American Psychological Association and disseminated as part of their Fight for Your Rights: Take a Stand Against Violence campaign. The American Humane Association's (1996) Growing Up Human in a Violent World: A Parent's Guide provides developmentally sensitive information about children and animals and the significance of animal abuse. The Guide also includes educational strategies appropriate for preschoolers and some designed for elementary and secondary school students.

- Youth should be surveyed about their treatment of animals. Because animals may often be abused covertly, parents and other adults may not be the best sources of information about this behavior problem. To obtain a better estimate of the incidence of animal abuse, youth surveys of violent behavior should include self-report items such as “Have you hurt an animal on purpose?” or “Have you made an animal suffer for no reason?” Also, witnessing animal abuse is a form of exposure to violence that should be routinely assessed because it may have significant effects on young people (Boat, 1999). Often children are deeply attached to their pets and observing the violent abuse or death of a pet at the hands of others may be emotionally devastating.

Assessment and Treatment

As part of the search for effective youth violence prevention and intervention programs, animal welfare organizations have been developing educational and therapeutic efforts that incorporate "animal-assisted" or "animal-facilitated" components (Duell, 2000). The underlying theme of many of these programs is that teaching young people to train, care for, and interact in a nurturing manner with animals will reduce any propensity they may have for aggression and violence. These programs assume that children are more likely to commit animal abuse when their capacity for empathy has been undermined or compromised (for example, by years of neglect or maltreatment—see Bavolek, 2000). Developing a sense of empathy for animals is assumed to be a bridge to greater empathy for fellow human beings, making violence toward them less likely.
The development of animal abuse assessment and intervention programs is accompanied by a number of issues related to evaluation and accountability:

- Although formal protocols for the clinical assessment (Lewman, 2000) and treatment (Joy and Randour, 1996; Zimmerman and Lewman, 2000) of animal abuse are beginning to emerge, they are still at a formative stage of development and their effectiveness is difficult to evaluate.

- Attempts have been made to create typologies for perpetrators of animal abuse, similar to typologies for predictors. These typologies have intuitive appeal, but their utility has not been empirically assessed. Whether using the proposed categories of animal abusers can facilitate the selection of appropriate therapeutic interventions remains to be determined.

- Given the challenges of incorporating animals into the therapeutic process (Fine, 2000), evaluation of animal-facilitated therapy programs must move beyond anecdotal evidence. Katcher and Wilkins (2000) provide an evaluation model in a study of animal-facilitated therapy for children with attention disorders. The model should be expanded to programs for youth with CD.

- Evaluation of intervention effectiveness will continue to grow in importance because, in some jurisdictions (e.g., California, Colorado), courts may recommend or mandate assessment and treatment of individuals convicted of certain forms of animal abuse (Frasch et al., 1999). The effects of such programs on recidivism have not been examined.

## Conclusion

Although vandalism may represent costly and psychologically significant destructiveness (Goldstein, 1995), smashed windshields and grafitti walls do not feel pain or cry out when they are damaged. Animals, however, do express their distress when they have been abused, and their distress calls for attention. This Bulletin has provided an overview of the underreported and understudied phenomenon of animal abuse in childhood and adolescence. Addressing cruelty to animals as a significant form of aggressive and antisocial behavior may add one more piece to the puzzle of understanding and preventing youth violence.

## Resources

**The American Humane Association**

63 Inverness Drive East
Englewood, CO 80112–5117
303-762-0900
303-762-5333 (fax)
www.americanhumane.org

**The National Resource Center on the Link Between Violence to People and Animals**

63 Inverness Drive East
Englewood, CO 80112–5117
877–LINK–222 (877–546–5222)
link@americanhumane.org

The American Humane Association (AHA), established in 1877, includes both child protection and animal protection divisions. AHA operates the National Resource Center on the Link Between Violence to People and Animals, provides training to professional groups across the country, and has brochures, fact sheets, and special issues of Protecting Children available that are devoted to this topic.

**The Humane Society of the United States**

First Strike™ Campaign
2100 L Street NW.
Washington, DC 20037
202-452-1100
888-213-0956
www.hsus.org/firststrike/

The Humane Society of the United States (HSUS) launched the First Strike™ Campaign in 1997 to raise public and professional awareness about the connection between animal abuse and human violence. The campaign provides training for law enforcement officers, prosecutors, social service workers, veterinarians, mental health professionals, educators, and the general public on the importance of treating animal abuse as a serious crime and an indicator of other forms of violence. A complete list of resources available through the HSUS First Strike™ Campaign is available at the Web site and can also be obtained by calling the toll-free number (both listed above). Resources include a free campaign kit with brochures and fact sheets. A general brochure, a brochure on domestic violence, and a brochure for children are available in Spanish. Also available are the First Strike™ Campaign video and public service announcements,
Mental Health Professional + Horse Professional = Value Greater Than the Sum of Its Parts

By Marilyn Sokolof, Ph.D. and Merevek Stuart

Equine-facilitated psychotherapy is a dynamic treatment approach for working with clients with emotional problems and the combined resources of a mental health professional and a horse professional (in addition to the horse!) make for a powerful treatment team. The role of the mental health professional—to attend to the psychological needs of the client and the role of the horse professional—to translate those needs into horse-related activities, are valuable adjuncts.

Our History

We began our equine-facilitated psychotherapy program (unknowingly) 20 years ago when we became riding buddies. Through the years we have learned to appreciate and rely on each other for many things. We have bonded with each other for healing "pony rides" when one or the other of us was recovering from some emotional or physical stressor; we have groomed for each other at clinics and shows; we have been each other's shoulder to cry on when we were frustrated and discouraged about our own riding; we have advised each other on all matter of horse concerns. It is difficult to imagine doing this business without each other and we know we are lucky to have this history together. However, the value of having both a mental health professional (MHP) and a horse professional (HP) goes beyond our personal story; as we have progressed with our program, the importance of having both professionals on board has become clearer.

Benefits

Safety is a top priority and the benefit of having two people to handle horses, equipment, riders, etc., is obvious. Emotional safety also is enhanced the MHP becomes available to process issues with a client, to calm anxieties, to attend to emotional nuances, while the HP manages the horses and continues instructing the other clients. Additionally, equine-facilitated psychotherapy, like all psychotherapy, can be emotionally demanding and disturbing and both professionals' emotional safety is taken care of in the opportunities to discuss the sessions.

The HP becomes an adjunct in the therapeutic process and is relied on for more than just skills as a horseperson. The HP may catch on to something that the MHP has not noticed in one of the clients, support a position, or present a disagreement that allows clients to think about a range of options. Most important, this is another person who listens and cares.

Where the whole becomes greater than the sum of the parts is in the example: the HP and the MHP set for the clients about relating to others in a healthy fashion. We are an example of connectedness and mutual respect. We work on our own personal relationship because we know it is a tabloid for our clients to see.

The Nuts and Bolts of the Partnership

While the MHP is in charge of the therapy and the HP is in charge of the horse activities, the teamwork depends on shared participation. It is important for the HP to be part of the therapy session in order to know what issues the clients are dealing with and what their state is on a particular day. Likewise, once the clients move to the horse activities, the MHP remains and active participant, sometimes stopping an activity to ask clients questions or taking a client aside to work on a particular issue. Occasionally the HP may ask the MHP to work with a client individually on the horse activity.

The HP and the MHP need to discuss what is happening in the therapy sessions. The HP may hear and see things that may be disturbing or confusing, or may need clarification of the diagnoses in order to structure the horse activity. It is important to allow time before the clients arrive to discuss the previous session, up-date each other on the clients and/or horses and plan the day's activities. Once the clients are gone, there should be time to debrief.
particularly difficult session, you may need to check in with each other between sessions. When this is the case it is particularly important to be supportive of each other and if possible find something to laugh about, or plan to go for a ride together!

The Hard Part

Working with a partner is not always an easy assignment for some of us, especially, it seems, for those who are independent enough to become riding instructors or mental health therapists. Put the two professions together and what you may end up with is a tug of war. However, this is not always a bad thing; good ideas come from diversity, the challenge is in knowing how to use it constructively.

Riding instructors are used to working alone in the ring as the master of their kingdom, expecting riders, jump crews, grooms and barn laborers to literally jump when told. The horses listen to the “boss horse.” It is a matter of safety and economics. Consequently, the riding instructor must have a deep and abiding respect and trust for the therapist in order to give over some of that authority. Likewise, therapists have to be willing to relinquish some control, not always an easy task where such responsibility is not usually shared.

How does this translate from paper to barn? Having defined roles is critical. Questions must be answered:

- Who is in charge of what?
- How do you change roles?
- Is there a time when you are both in charge?
- If you disagree when in session, how do you resolve this without creating a problem for the clients?

Safety issues create situations where it is most important to know who will be in charge when. There will be occasions when one or the other of you will feel that something is physically or emotionally unsafe for the client or the horse. Either of you should be able to bring things to a halt or signal to the other that there is a possible problem. Disagreements may occur. Respect and trust become so important because immediate action may be critical. It is best to have talked out scenarios and have a plan of action beforehand.

Knowing when to make these adjustments requires an ability to communicate non-verbally as well as verbally. Fortunately, both horse people and therapists are adept at using non-verbal cues as part of their profession. If you listen to each other like you do your horses’ clients, your communication with each other can become quite intuitive.

Final Thoughts

Of course the MHP should be licensed and insured to practice and the HP should be competent with all aspects of horses and their management and be a NARHA Certified Instructor.

Additionally, in order to be a fully-functioning partner and to be of help to the horse professional, the mental health professional should:

- Have a familiarity with horses
- Preferably be a NARHA Certified Instructor

Likewise, in order to be a more effective partner in the team, the horse professional should:

- Have a strong personal interest in helping others empower themselves towards emotional growth
- Be able to be diligent about the clients’ rights to confidentiality and be willing to comply with all ethical standards
- Be willing to accept the MHP’s decisions that may contradict the riding lesson format at any given time
- Be willing to be educated regarding psychological diagnoses, indications & contraindications, treatment modalities, psychotropic medications, psychological emergencies and more
- Understand that they are not the therapists and may not identify themselves as such
- Be a person who understands the sensitive nature of the process of therapy and who is committed to their own personal journey of emotional health (preferably have been therapy clients themselves)

Thus, the partnership between mental health professional and horse professional can be a dynamic and beneficial arrangement for all concerned. The HP and MHP can be very different people and live in very different worlds outside of the program but both must:

- Be committed to the excellence in the individual professions that are brought to the partnership
- Appreciate, respect and trust each other and be willing to continue developing good communication pathways

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MEMREE STUART is a professional librarian, with 29 years experience, most of them in various positions at the management team. She earned through Preliminary 3-Day, has an AHS License Technical Delegate and was elected to the United States Combined Training Association Board of Governors from 1984-89. Memree also owns and manages Olden Farms, where she boards, teaches and trains off-track thoroughbreds for their next career and works with abused horses.

In 1998, Marilyn and Memree developed the equine-facilitated psychotherapy program horse/ powers, which operates as of Manor Therapeutic Riding Association in Ocala, FL. They are NARHA Certified Riding Instructors and EFHA Members. Memree serves on the EFHA Standards and Research Committees and Memree the Education Committee.
Partnership

For centuries, horses have been utilitarian tools in war and peace.

Can humans develop a new model of relating to equines as partners?

Horse as Object or Partner?

The dictionary defines “use” as “to consume or expand,” as in use up. Use is a verb, an action, it is applied to inanimate objects or commodities and implies a right on the part of the user. The word “partner” is defined as “joins activity, dancing together or working together,” it implies consent and agreement on the part of all participants. This difference demonstrates the very values and goals of respect, self-worth, self-value, empathy, and cooperation that mental health and learning programs, as well as all NARHA centers, can promote.

Most equine facilitated mental health and learning programs are based on a specialized relationship with equines. In these programs, horses are considered “in partnership” with people, rather than “used” to facilitate human growth and learning. This is a crucial distinction ultimately affecting program outcomes.

It is not just mental health programs that can incorporate the attitude of partnership with the horse to improve and enhance program outcomes. Many physical therapists, instructors and participants at NARHA Centers are learning that equines treated as partners are more interactive with people and experience less stress than those treated as tools.

The Five Principles of Partnership

Five interconnected principles summarize the core elements of equine/human partnership and can create a stronger relationship. If practiced consistently, these principles develop an increased level of trust with the horse.

1. Respect

Content horses must have lives outside of their relationship with people. Horses should be given time to develop friendships and participate in herd-type activities, unconfined to stalls. These relationships must be respected.
Tool Mentality: A mare has made friends with the horse in the next stall to the extent that she is getting difficult to handle in the ring unless her buddy is with her. The center resolves the issue by separating the friends and moving one horse to another part of the barn. The attitude is that “They will get over it,” even though there is noticeable separation anxiety for each horse.

Partnership: Respecting the mare's need for companionship, the center increases the horses’ time together, allowing them to touch and groom each other as much as possible. Each horse is then trained through positive reinforcement techniques to spend lessons apart in a quiet and relaxed manner.

2. Seeing the Horse's Point of View

Horse perceptions of the world are different from our own and are accurate for them. We must adapt our ways of thinking about situations. One example of seeing the horse's point of view is to train center staff and volunteers to understand that feeding, cleaning and work routines are important to horses. Altering routines can have a negative impact on horse behavior.

Tool Mentality: Center horses have to conform to a varied system of barn management, horses have to cope with multiple handling styles and constant scheduling changes. This attitude reflects a real disregard for the impact of these changes on the horse and minimizes the horse's needs.

Partnership: Everyone at the Center can be trained to expand their perception and see how horses respond when routines are changed. For example, showing people unfamiliar with horses how excited with anticipation equines get in the hours before feeding time can be a revelation. Having all staff watch a video tape on the regimented day of a wild mustang herd (divided between feeding, going to water, grooming time, sleeping breaks etc.) can start the process of offering Center horses the predictable routine that satisfies their need for consistency.

3. Emotional Awareness

Partnership with horses requires people to take responsibility for their emotional impact on horses.

Tool Mentality: A screwdriver behaves the same whether the person is happy or angry. Center staff believes that their horses behave and perform regardless of what is going on with people because they are well trained and just do their job. When horses misbehave, they are said to be stubborn, and retraining and stem handling will set them “right.”

Partnership: Recognizing the emotional impact people have on the horse, rather than blaming the horse for its responses, helps humans become more observant of the ways their own emotions affect the animal. Being aware of emotions can be difficult for many Center instructors, therapists, volunteers and participants.}

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Continued from page 33.

more aware of our body posture, facial expressions and voice volume is a first step in recognizing our emotions. Horses are especially reactive to emotions of anger, stress and anxiety.

Teaching the Center team to create a calm mood in the barn and the arena (even on days when Center life is hectic) and to slow down before working with horses can have an immediate impact.

4. Mutually Beneficial Interactions

Partnerships require benefits for all participants. People do many things to horses without thinking about the benefits or irritation to the horse. Because people like being around horses we assume horses want to be around people.

Learning the body language of horses is a requirement to understanding them.

Individual horses experience preferences between people and how much contact with people they can cope with each day. It requires attentiveness to subtle signals to monitor horses for emotional wear and tear due to interactions with people. When a horse turns its back to the stall door when the groom approaches, a clear sign is being sent.

Interpreting that behavior requires a detailed familiarity of that individual horse and what may be causing the reaction.

Center staff and volunteers can work together to develop an “end of the day” assessment of each horse. Was the horse better off for the interactions with people that day or did the horse come out being “used up?” Too often the best horses are working the hardest, until the strain is just too much for them.

emotionally. Anticipating and preventing burnout is the surest way to let both people and horses benefit from the interaction. A stressful session for a horse should always be followed by a relaxing session, some T-Touch or time off with equine friends in the pasture. Care must be taken not to schedule too many challenging groups back to back.

5. Engagement

Are horses participants in interactions or made to comply with rules of behavior?

Endo Mentality: The horse must comply with our directions. “Don’t let the horses win” is the rule, even if it takes six people and a buggy whip to force an unwilling horse into a trailer. This focus assumes that horses are lazy, resistant or stubborn, and invites handlers to use whatever means necessary to make equines comply.

Endo Mentality: The notion that the animal has some freedom of choice can be challenging to apply in practice. But, in a genuine partnership, the horse has to be given the choice of interacting with people and a ‘no’ must be accepted. For example, a Center tried to load a vaulting horse to go to the fairgrounds for a demonstration. The mare would not load. The staff informed the participants that they might not go to the event. Following a discussion among the group, one of the children told the horse he understood that she didn’t want to go to the fair. He said that he really wanted to vault, though, and wished she would just get on the trailer. He promised her carrots if she did. The staff gives it one last try, leading her back to the ramp and, amazingly, she walked right on. This real example shows that the attitude of partnership around this horse may have been enough for her to feel safe enough to get on the trailer.

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Jayne Stewart is aTellington TTouch Practitioner and has many years of experience in various disciplines in the horse industry.
Glossary

Thumbnail Glossary

EAA  Equine Assisted Activities
EAT  Equine Assisted Therapy
EFP  Equine Facilitated Psychotherapy
EFL  Equine Facilitated Learning
ESMHL Equine Specialist in Mental Health and Learning
HPOT  Hippotherapy
HPCS  Hippotherapy Clinical Specialist
TR  Therapeutic Riding
EFMHL Equine Facilitated Mental Health and Learning

Glossary of Terms

Activity Site – locations at which center activities are being provided.

ADA – Americans with Disabilities Act, signed into law in 1990, which provided the world's first comprehensive civil rights law for people with disabilities.

Area – Any working space with designated boundaries.

Arena – A working space defined by structural barriers used for program activities.

ASTM – American Society for Testing and Materials, an organization that helps establish standards for various items, including components of helmets. (See SEI).

Assist – The PATH Intl. Certified Instructor assists the therapist during the treatment session (if the therapist is not a PATH Intl. Certified Instructor). The PATH Intl. Certified Instructor should be directly involved in the treatment session to assure safety regarding the equine, tack and equine environment. This may include helping with the preparation of the equine/equipment, direct involvement in the session or visual observation of the session.

Center – a structured organization that provides equine assisted activities to persons with disabilities and persons without disabilities.

Center Activities – all events, instructional lessons, therapy sessions or other functions involving participants occurring under the leadership or supervision of center personnel.

Center Administrator – the person(s) responsible for developing and implementing the policies and procedures used in managing the work of the organization.

Center Representative – the individual who is determined by the center to be responsible for the accreditation process and on-site visit.

Competition – Individual or team sports at the local, regional, national, or international level. Integrated or specialized competition that can be breed or activity based.

Consulting – Providing assistance by providing professional expertise. This may include answering questions related to general health issues, health questions related to specific participants, doing evaluations with recommendations regarding handling or activities, recommendations for health and safety of the staff/volunteers, etc.
Contain – To have within; hold.

Contract – A legally enforceable agreement between two or more parties.

Designate – To indicate and set apart for a specific purpose; to point out.

Direct Service Health Professional – see Licensed/Credentialed Health Professional.

Directly Supervising – The certified instructor is at the activity site and is aware of and responsible for the program activity in the arena and on the premises.

Discharge – To release or dismiss.

Driving – Activities related to carriage driving. Following PATH Intl. Standards for driving conducted by a PATH Intl. Certified Instructor. May be considered equine assisted therapy if driving activities are incorporated by a therapist into a treatment plan. May also be done in competition.

Educator – An educator/teacher licensed or sanctioned by the state, school district, department of education or equivalent designation.

Equine – A general description inclusive of horses, ponies, mules, donkeys, or miniatures.

Equine Activity – Any activity that involves an equine.

Equine Activity Liability Act – General heading for, and frequent name of, a state statute governing liabilities for equine activities and, in many instances, mandating the usage of “warning” signs and requiring the use of special language in certain contracts used in equine activities.

Equine Assisted Activities (EAA) – Any specific center activity, i.e., therapeutic riding, mounted or ground activities, therapy, grooming and stable management, shows, parades, demonstrations, etc., in which the center’s participants, volunteers, instructors, and equines are involved.

Equine Assisted Therapy (EAT) – Treatment that incorporates equine activities and/or the equine environment. Rehabilitative goals are related to the patient’s needs and the medical professional’s standards of practice.

Equine Facilitated Learning (EFL) – An educational approach that includes equine facilitated activities incorporating the experience of equine/human interaction in an environment of learning or self-discovery. EFL encourages personal exploration of feelings and behaviors to help promote human growth and development. It may be conducted by a PATH Intl. certified instructor, an educator, a coach or a therapist with special training in partnership with horses to address mental health needs. Goals may be related to self-improvement, social interaction, increased awareness and/or education.

Equine Facilitated Mental Health (EFMH) – Inclusive of equine assisted activities and therapies with a focus on mental health issues.

Equine Facilitated Psychotherapy (EFP) – Experiential psychotherapy that includes equine(s). It may include, but is not limited to, a number of mutually respectful equine activities such as handling, grooming, lunging/lungeing, riding, driving, and vaulting. EFP is facilitated by a licensed/credentialed mental health professional working with an appropriately credentialed equine professional. Although EFP may encompass many different activities, the activities themselves are not the goal. Rather these activities assist reaching the psychotherapy goals set by the mental health professional and the client.

Facility – Any building or parcel of land on which the center conducts its activities and business.
Header – The person who stands at the equine’s head, during halts, that is responsible for keeping the equine relaxed and still.

Health Professional – see Licensed/Credentialed Health Professional.

Hippotherapy (HPOT) – Hippotherapy is a physical, occupational or speech therapy treatment strategy that utilizes equine movement. This strategy is used as part of an integrated treatment program to achieve functional outcomes.

Hippotherapy Clinical Specialist (HPCS) – An experienced, licensed therapist (PT, OT, SLP) who has demonstrated an advanced level of knowledge in hippotherapy by successfully completing a national board written examination.

Hippotherapy Team Members – Those involved in the provision of hippotherapy services. Prior to the hippotherapy session, the team will be the PATH Intl. Certified Instructor and the therapist (if the therapist is not a PATH Intl. Certified Instructor). During the hippotherapy session, the hippotherapy team is most often the therapist, the equine handler, the sidewalkers—all those involved with providing services to the patient. In decision making, the patient is often thought of as a part of the hippotherapy team.

Horse Handler, Horse Expert, Horse Leader, Equine Handler, Equine Expert, Equine Leader, Equine Professional, Equine Specialist in Mental Health and Learning – Terms which may be used to indicate the person handling the equine during a session and/or training and conditioning the equine for participation in equine assisted activities. Usage may vary by discipline. The HPOT session where an equine is long lined might have a horse handler, whereas, the person leading the equine in a therapeutic riding lesson may be the horse leader.

Instructor In-Training (IT) – A candidate who has successfully completed phase one of the Registered Instructor Certification process.

Interactive Vaulting – A process that engages participants in horsemanship activities, movements around, on and off the equine or barrel and gymnastics positions on the back of the equine. The specially trained equine works in a circle on a lunge/longe line at the walk, trot or canter. This dynamic environment offers educational, social, creative, and movement opportunities. The use of Interactive Vaulting for individuals with disabilities varies depending on the population served and the goals obtained.

Lead Visitor – PATH Intl. site visitor who is assigned to the administrative responsibilities of the visit by the Accreditation Sub-Committee.

Licensed/Credentialed Health Professionals – Refers to physical therapists, occupational therapists, speech-language pathologists, psychiatrists, psychologists, physicians, nurses and rehabilitation specialists. Health professionals providing direct service “therapy” through equine activities should have additional specialized training in the use of the equine as a component of treatment in their respective areas of expertise.

Legally Authorized Individual – That person at a center who is empowered to sign contracts and legal documents for the organization.

Mental Health Professional – A licensed and/or credentialed medical professional who specializes in the treatment of individuals with psychiatric, psychological, emotional or behavioral diagnoses. Those psychiatrists, psychotherapists, mental health counselors and others having met the criteria to legally and independently provide psychotherapy and/or mental health counseling, and mental health treatment, in the state in which the services are being delivered.

PATH Intl. Member Center – A center that has established membership with PATH Intl. and agrees to comply with the PATH Intl. Standards.
PATH Intl. Certified Instructor – An instructor of therapeutic horsemanship who is certified by PATH Intl. at the Registered, Advanced or Master level or who holds an approved adjunct certification.

PATH Intl. Member – An individual who fulfills the membership requirements associated with the North American Riding for the Handicapped Association.

PATH Intl. Registered Therapist – A licensed therapist or therapist assistant (PT, OT, SLP, COTA, PTA) who has registered with PATH Intl. upon completion of the AHA, Inc. approved hippotherapy coursework and the requisite number of hours of practice in hippotherapy.

Occurrence – An event that disrupts normal procedure or causes a crisis.

On-Site – Location where administrative or other functions of a center occur.

Participant – A general description of the persons that take part in equine assisted activities at a PATH Intl. center for their benefit such as riders, vaulters, clients or patients. There will be varied usage depending on the discipline. For instance, in a therapy setting, it is appropriate to use patient or client; in a school setting, one may use the term student.

Personnel – A person, paid or unpaid, who has any responsibility related to the day-to-day activities of the center.

Posted - To fasten up in a place of the public view; to put up signs.

Randomly Selected – Visitor selection from files representing a cross section of center documents.

Rehearsal – A practice exercise.

SEI – Safety Equipment Institute, an organization which certifies certain types of equipment, including equestrian protective headgear. (See ASTM).

Securely Maintained – To be placed in an area that would not allow for unauthorized use or loss.

Site Visitor, Associate Visitor – PATH Intl. individual members who successfully complete a visitor training course and are approved by the PATH Intl. Accreditation Sub-Committee. These individuals volunteer to visit and score centers according to current accreditation standards.

Tandem Hippotherapy (T-HPOT) – A treatment strategy in which the therapist sits on the equine behind the patient in order to provide specific therapeutic handling as part of an integrated treatment protocol. If the therapist (PT, OT, or SLP) is unable to be mounted, they will directly supervise the patient handling by another Therapist Aid (TA), in compliance with their state practice act. Additional personnel required for T-HPOT include a PATH Intl. certified riding instructor or equine expert who handles the equine, two side-walkers (one of whom may be the therapist) to assist with safety, and a specifically trained, conditioned equine. For this definition, therapist or TA refers to the person on the equine behind the patient. The therapist determines if T-HPOT is indicated for the patient, and consults with the PATH Intl. recognized certified instructor or equine handler to establish if the facility has the resources to conduct a safe T-HPOT session and to choose the appropriate equine. T-HPOT exposes the therapist or TA and the patient to greater risk than in other types of equine assisted activities and therapies and should be undertaken only with the utmost caution and consideration for safety. Because two people are on the equine, it is more stressful on the equine than other activities, and should be done only with equines adequately conformed, trained and conditioned for the task. Because of these stress and safety factors, T-HPOT should be chosen only after exhausting other options for treatment, and should be self-limiting with the expectation that the patient will quickly progress from this intervention.
**Therapist’s Aid (TA)** – The person that is trained and directly supervised by the therapist to perform specific patient handling skills in a situation where the therapist is unable to perform the task. An example may be that the TA would handle the patient during a T-HPOT session when the therapist may not be tall enough to work with a patient safely on the equine.

**Therapeutic** – An activity is therapeutic if a participant derives benefit, shows improvement or feels better once engaged. An activity can be therapeutic without being considered as therapy. In general, EAAs may be described as therapeutic, but are considered treatment without fulfilling specific requirements. (See Therapy, defined below).

**Therapeutic Horsemanship** – Equine activities organized and taught by knowledgeable and skilled instructors to people with disabilities or diverse needs. Students progress in equestrian skills while improving their cognitive, emotional, social and behavioral skills.

**Therapeutic Riding (TR)** – Mounted activities including traditional riding disciplines or adapted riding activities conducted by a PATH Intl. certified instructor.

**Therapeutic Driving** – Activities related to carriage driving. Following PATH Intl. Standards for driving conducted by a PATH Intl. certified instructor. May be considered equine assisted therapy if driving activities are incorporated by a therapist into a treatment plan. May also be done in competition.

**Therapy** – Providing therapy or treatment, or billing for services with a third party may be done by a licensed/credentialed professional such as a PT, OT, SLP, psychologist, social worker, MD, among others. Laws differ by state.

**Treatment** – Services in which therapy is provided. Generally thought of in a medical model. (See Therapy).

**Treatment Session** – The period of time in which professional therapy services are provided. This will always involve the therapist and may involve others, depending on the nature of the treatment and the needs of the therapist.

**Vocational Rehabilitation** – Equine related activities that may include work hardening, work re-entry or vocational exploration. Participants are young adults or adults. May be considered equine assisted therapy if integrated by the therapist as part of a treatment plan.

**Volunteer** – Unpaid individual who, under the direction of the center administration, assists with the ongoing activities of the center.

**Working Area** – The location where mounted lessons are being held.
Books and Articles List for PATH Intl. Equine Specialist in Mental Health and Learning Workshop
From the perspective of the mental health practitioner


Brooks, S. (1997), Program for Misty the Blind Horse, Green Chimneys Children's Services, Brewster, NY. (Handler's Program for incorporating a near blind horse into a program for children looking at their own challenges.)


Resources for the Equine Specialist in Mental Health and Learning


Talking with Horses, Henry Blake, Trafalgar Square Publishing, 1975
Authors- horse behavior & psychology, Dr. Kiley-Worthington, Lucy Rees, Owen MacSwiney

True Horsemanship Through Feel, Bill Dorrance, Leslie Desmond, the Lyons Press, 2001

Understanding Horses, Garda Langley, Wilshire Book Co., 2000


Natural Horse-man-ship, Pat Parelli, Western Horseman Magazine, 1993

Consider the Horse, A Good Horse is Never a Bad Color, Horses Never Lie, Mark Rashid, Johnson Books

Inside Your Horse’s Mind, a study of equine intelligence and human prejudice, Lesley Skipper, J. A. Allen, London, 2001


Equestrian Instruction Integrated Approach to Teaching and Learning, Jill Hassler-Scoop,

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Psychotherapeutic Implications of Equine Senses, Behavior and Grooming by Kat Zilboorg

When Acting Up is Acting Out by Boo McDaniel

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Working With Animals in a Healing Context by Susan Brooks

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The Care of Pets Within Child Abusing Families by Elizabeth De Viney, Jeffery Delbert, Randall Lockwood

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Avoiding Burnout in Your Therapy Horse by Dallas Crain and Tami Lewis

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Ethics of Using Horses, Chris Irwin, Strides

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