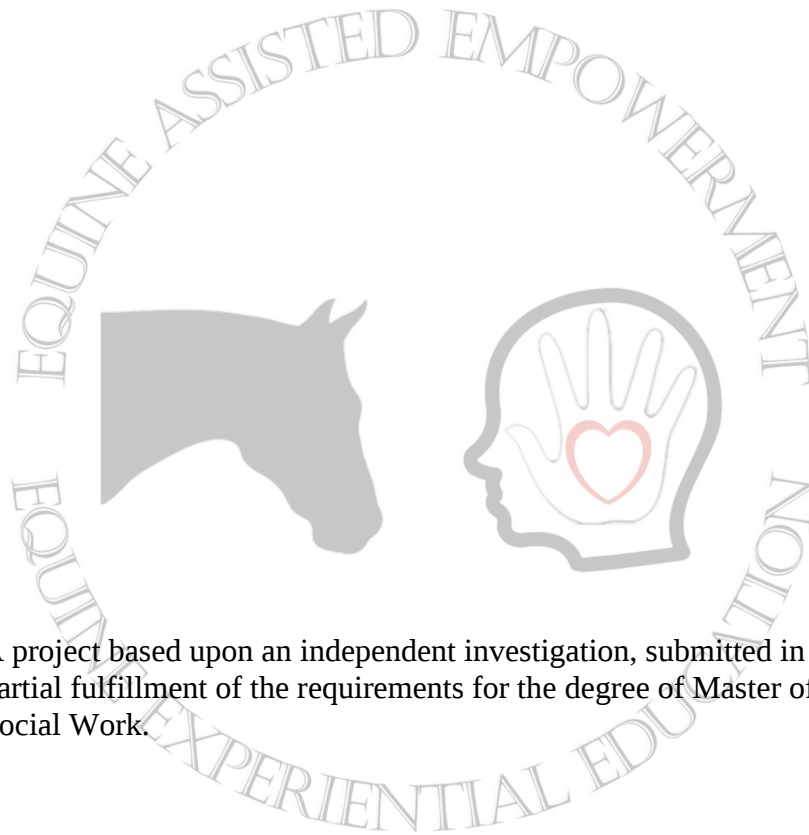


Ann Marie Sexauer
Equine Embrace: Touch and the
Therapeutic Encounter in Equine
Facilitated Psychotherapy from the
Perspective of the Clinician

Abstract

This study was undertaken to examine touch between human and equine in the therapeutic context from the perspective of the clinician conducting an equine facilitated psychotherapy session. Thirteen practitioners, twelve from the mental health field and one life coach, participated in a single semi-structured in-depth interview. The practitioners were questioned on their views of touch between themselves and their clients, and between horse and client. They were also asked if their touch practices changed with the presence of an animal, as well as what outcome they saw due to clients touching the horse, and in which situations. The findings showed that the majority of practitioners found they touched their clients with more frequency in the presence of animals, and that touch allowed the client to attach to the animal and thus work more safely from a secure base on a variety of therapeutic goals.

Equine Embrace:
Touch and the Therapeutic Encounter in Equine Facilitated Psychotherapy from the
Perspective of the Clinician



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

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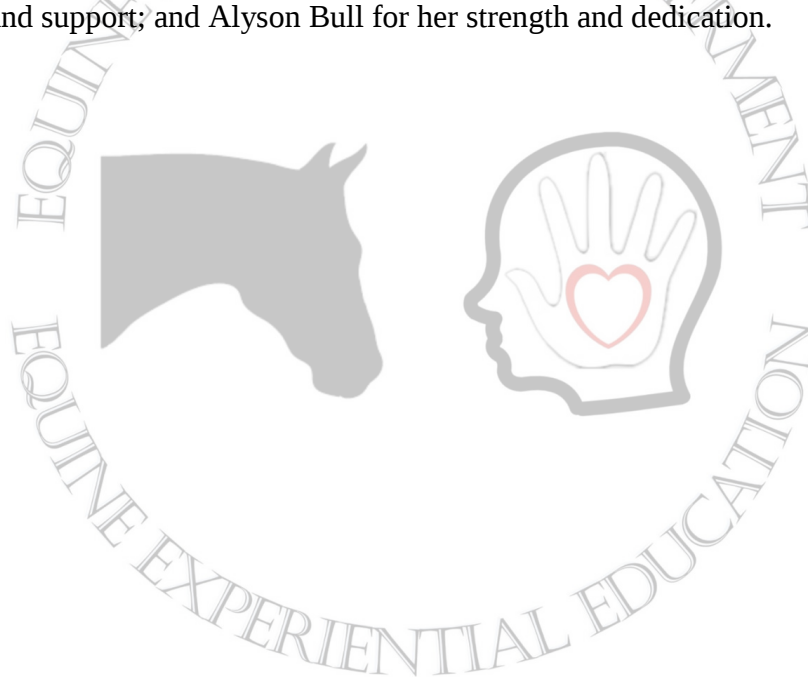


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Chapter I

Introduction

The purpose of this study is to explore touch between client and horse during equine facilitated psychotherapy (EFP) from the perspective of the clinician. Touch during the therapeutic encounter is a controversial subject when it occurs in a traditional therapeutic setting. However, in an EFP setting, touch between the client and the horse is expected and one could argue required. How do clinicians who arrange these encounters view this? What decisions do they make regarding this therapeutic technique, what results do they see and from whom? Research evaluating EFP has begun to appear in the literature with both positive and mixed results, but much more specific research is needed to further evaluate specific strengths and weaknesses of this modality. This study aims to explore one unique aspect of this form of therapy in an effort to deepen our knowledge of this intervention and its potential benefits.

The inclusion of a horse into a therapeutic setting automatically makes this experience quite different from a traditional office setting. The location is usually outside, clothes appropriate to this location must be worn, and the presence of the animal itself with its attending behavior and actions sets a different stage for a client. Within this context, one particular difference the animal offers is the presence of touch. The animal and human touch often from the first 'meet and greet' session to every subsequent session through grooming, riding, catching, leading and general handling. Potentially, touch between client and therapist would occur in the same session as touch between client and horse. To understand more fully how clinicians saw these interactions, and how they utilized this difference that is specific to this form of therapy, thirteen practitioners were engaged in an in-depth interview on the subject. They were asked a series of questions covering their views on touch between client and clinician, and touch between

client and horse, as well as if they saw any difference in responses to touch amongst their own client base.

One of the results that came from these interviews was the fact that clinicians found touch between human and equine in a therapeutic setting to be potentially healing and potentially triggering. Since a powerful reaction is possible, they stressed the need of an experienced and engaged clinician to oversee the process in order to titrate the process in line with the needs and abilities of the client at that present moment. This finding, in part, marks the importance of this study and others like it. The more information obtained to elucidate the potential benefit as well as outline the potential harm, the more chance clinicians have to tailor their interventions for the health of their clients. If there is a potential for wounding, it is important to have the necessary knowledge to avoid the instances where such potential is likely.

Touch is also a highly debated subject in therapeutic circles. Though many recognize the human need for touch and its potential benefits, the possibility of harm to the client make many adopt a no-touch policy. Or, the possibility of touch being misconstrued by the client could end in a lawsuit for a therapist. Thus, the benefits of touch come with risks. However, if there are alternative vehicles that can deliver some of the benefits of touch to clients with lower risk then those vehicles deserve consideration. This study is designed to give that consideration the vehicle of equine human touch. The following pages explore touch in the therapeutic setting through existing literature, then more fully explain the methods and results of the study while also suggesting the implications this has for the field of social work.

Chapter II

Literature Review

Introduction

What does the physical contact between horse and client in an equine facilitated psychotherapy (EFP) session mean to the clinician who is conducting the session? The literature review intends to support this question by examining three broad categories: animals and human health, touch in the traditional therapeutic encounter, and finally the possible synthesis of touch between horse and client in a therapeutic encounter. The first section starts with a broad look at animals and their relationship to both physical and mental health through history, touching on practices and publications used in past times, and ending with a look at the international groups and debates seen today. The focus is then specifically shifted to horses in the therapeutic setting, how that field developed, what it looks like today, and the research and theories used to support it. The second section explores touch in the therapeutic encounter, starting with a history then moving into the relevant studies outlining the possible benefits and drawbacks of touch between therapist and client. Attention will also be paid to which therapists decide to touch, how they make that decision, and what clients say about how touch did or did not benefit them. Abuse of clients through sexual relationships between client and therapist will be noted, as well as a cultural critique of touch in Western culture. The review will end with a summary of some possible overlaps between the first two sections, more closely examining the intersection of touch between horse and human in a therapeutic encounter.

Animals and Human Health

In ancient Greece and Rome, dogs were kept in holy temples or shrines and partnered with individuals who feared for their sanity. Those with such fears kept the dogs close to protect their mental health. In the 1700's the York Retreat introduced companion animals to psychiatric patients and continues to support this concept today (Hallberg, 2008). Florence Nightingale, noted in American history for her contributions to the field of nursing, stated in 1859 "a small pet is often an excellent companion for the sick, for long chronic cases especially." In 1980, the first paper discussing animals as therapeutic agents was published in a currently recognized medical journal. This study demonstrated that owning a pet significantly increased the one year survival rate of patients discharged from a coronary care unit compared to non-owners (Vidrine et al., 2002). Studies have demonstrated positive results in both physical and psychological symptoms in various populations when animals are incorporated into the treatment milieu (Klontz et al., 2007).

The international Association of Human-Animal Interaction Organization (IAHAIO) was formed in 1990 as an advisor to the United Nations and in 2004 was awarded working partner status with the World Health Organization in recognition of the importance of the bond between humans and animals and its contribution to human health. The IAHAIO, in cooperation with Purdue University, publishes a peer reviewed journal called Anthrozoos, which publishes professional articles focusing on the human-animal bond in an effort to provide the needed literature to bring validity to the field (Hallberg, 2008).

Odendaal, a South African author, helped begin an international dialogue on animal-human interaction by publishing several articles in international journals. Odendaal's research focuses on the human need for attention. He posits that the therapeutic role of a companion

animal is to provide this attention. Further, he notes the benefits are most seen among populations he describes as “weaker” such as the elderly, chronically mentally ill people, prisoners, substance abusers, and anyone who cannot compete “on an equal basis for attention among healthy, adult people because of their place in society in relation to the nucleus of activities.” Odendaal suggests humans typically receive the needed attention for emotional health from other humans, but that research has shown that animals can offer similar companionship. Thus, the ability to exchange a human for an animal is at the root of the therapeutic value of animals (Hallberg, 2008).

In 1988, Barker and Barker embarked on research that led to the conclusion that dog owners were as emotionally close to their dogs as to their closest family member. In fact, one third of the dog owners who participated in their study, were ranked closer to their dogs than to any human family member. This study, in combination with other literature and theories already published, provoked some to question Odendaal’s findings. Is it possible that Odendaal’s notion of “weaker” populations is broader than he imagined? If so, what does that mean for the growing field of animal assisted therapies, and humans relationship to animals in general? (Hallberg, 2008).

There is a growing body of literature that documents the healing power of companion animals. Between 1988 and 1992 fifty-two scientific papers documenting research in the field of animal assisted therapy were published. All 52 studies concluded animals were beneficial for humans either emotionally or physiologically. However, relatively little comprehensive research has been published in peer review journals that document how the *horse* is physically and mentally healing for humans (Hallberg, 2008).

Horses in the Therapeutic Setting

History

The written record supporting horses as therapeutic agents is slim, although not bare. In 1780, Tissot of France wrote in his book *Medical and Surgical Gymnastics* that when astride a horse, the walk was the most beneficial gait. In 1870 Chassaine, a student at the University of Paris, published his thesis about the horse as a treatment modality for patients with neurological disorders (Hallberg, 2008). Since that time horses have moved from the realm of industry and production to pleasure, recreation, and competition. Their formalized potential to found an industry based on their ability to heal or teach humans began in the late 20th century.

In 1969, North American Riding for the Handicapped Association (NARHA) was created to help oversee this transition of horses from working or competing animals into agents that can heal or teach. NARHA focuses solely on horses and at that time focused on physical differences. In 1990, NARHA acknowledged that horses could be psychologically healing for humans as well (Hallberg, 2008). A subsection of NARHA called EFMHA (Equine Facilitated Mental Health Association) was formed and by 1997 had 225 members. EAGALA (equine assisted growth and learning association) is another nationally recognized group that provides training and support to practitioners. In addition, numerous programs and facilities offer equine based services in the fields of personal development independently, affiliated with no national organization (Hallberg, 2008). EFP is also associated by some in the field with concepts of biophilia and ecopsychology. These ideas study the human need for interconnection with nature in all its form (Hallberg, 2008).

Within the US, there are at least 700 centers that incorporate horses into mental health or educational goals. There are three internationally recognized associations with thousands of members designed to provide support to practitioners and clients who access these methods. Eighty therapeutic boarding schools in the United States utilize equine facilitated programming as part of their therapeutic programming. Some residential treatment centers, including the Betty Ford clinic, follow a similar practice. Corporate training experts, focused on team building and professional coaching, are also starting to use equine facilitated methods. Institutions of higher learning now offer degrees in this subject at the undergraduate and graduate levels. Mental health professionals are billing insurance companies for their work with clients and horses. The idea that horses can help humans better access themselves, while not necessarily scientifically validated, is gaining momentum in several industries (Hallberg, 2008).

Research

Horses are effective therapy animals because their large size commands respect. The experience is both physical and social (Ewing et al., 2007). Additionally, you can ride a horse, an activity not many other therapy animals currently in use can provide (Vidrine et al., 2002). Mounted activities on horseback have been shown to benefit children with cerebral palsy (Liptak, 2005) and to aid in the development of self-identity in typically developing youth. Research suggests that the horse can reinforce congruence in humans between the spoken word and body language (Vidrine et al., 2002).

A study conducted in 1993 examined 46 fifth and sixth grade girls with emotional and behavioral problems who engaged in a therapeutic riding (TR) program. The study found improved social acceptance, close friendships, and global self-worth (Vidrine et al., 2002). A 2001 study of at-risk adolescents engaged in a TR program found a significant decrease in

depression. A 2003 study of adolescents referred by residential treatment centers to a TR program found significant increases in feelings of self-esteem and internal locus of control. In addition, participants reported feelings of social acceptance and peer popularity. A post-test evaluation of participants in a TR program with physical disabilities demonstrated increases of self-esteem. A qualitative study in 2002 conducted with children in a residential center, demonstrated improved relationship building and increased communication among participants. A 2004 study of a five day TR program demonstrated significant decreases in anger among able-bodied children (Ewing et al., 2007). Therapeutic riding programs have demonstrated a positive impact on quality of life for people with disabilities (York et al., 2008).

Horses have also been used as a part of psychotherapy as a way to avoid entrenched defenses and habitual reaction. This allows participants to be more receptive to new ideas and behaviors. As riding is not a language-based therapy, it draws more on the right brain, in effect not engaging the detailed analysis of the left brain (Vidrine et al., 2002). Horses, due to their size and status as prey animals, can elicit a broad range of emotions and actions in humans. This, in a therapeutic setting, can be used as a catalyst for personal growth and awareness (Klontz et al., 2007).

Though these initial results examining horses in various therapeutic settings seem promising, there is a need for greater empirical and quantitative study (Ewing et al., 2007). In addition, some studies show mixed results. A nine week TR program that served youth with severe emotional disorders was evaluated, with the hypothesis that there would be significant increase in the youth's sense of self-esteem, interpersonal empathy, internal locus of control and a decrease in feelings of loneliness and depression. None of the above hypotheses were supported with quantitative measures. However, qualitative measures applied to the same study

showed positive results, including two children being mainstreamed into typical school settings (Ewing et al., 2007).

Touch and the Therapeutic Encounter

History of Touch in Western Psychotherapy

Touch has been an important foundation of healing traditions in many cultures throughout time. Although sexual contact between healers and patients was discouraged since the writings of Hippocrates, the suggestion that therapists should not touch their patients is a relatively new one tied to the historical development of psychoanalysis (Kertay, 1993). Historically, Freud linked eroticism, gratification, and touch closely together (Greene, 2001). He believed that optimal therapy required the therapist to be a blank screen on which patients could project fantasies, which could then be worked through. Self-disclosure or touch were deemed to diminish the neutrality of the therapist, and thus compromise the treatment. To touch would also be to gratify a patient's infantile sexual desires, which meant these desires would not be recognized and worked through and further damage the analysis. Due to these theoretical stances, touch of any kind was seen as inherently sexual and inappropriate, influencing the future of touch in the field for years to come (Bonitz, 2008).

The taboo against touch may be rooted in earlier traditions, as well. It has been suggested that since psychotherapy developed in Germanic, English and American societies that already had social prohibitions against touch, the growing psychoanalytic movement simply absorbed this taboo from their parent culture. It also reflects a body-mind split often found in Mosiac Law and Christianity. Western medicine expresses this idea as it divides practitioners into those who touch the body and those who do not, or physicians and psychiatrists (Durana, 1998).

In the early history of psychoanalysis, touch was divided roughly into two camps; those that used touch and those that did not. Those that did use touch sometimes founded their own schools and formalized a specific technique. Therapists espousing a humanistic orientation, including gestalt, were much more likely to view touch as a permissible technique. On some occasions, the promoters of these ideas became sexually involved with their patients, furthering the divide between the two schools of thought (Bonitz, 2008).

Reich was an early dissenter from Freud's view of touch. He observed that tension in muscles and breathing patterns seemed to correlate with character traits and emotional blocks. He developed a technique of pressing his fingers against the tight muscles of analysands as a way of breaking through resistance to treatment. His break with Freud signaled an official break between talk therapy and body work (Greene, 2001).

Touch in Development

The importance of physical touch in the experience of the infant is crucial and hard to over-estimate. Stern (1990) states it simply; "The ultimate magic of attachment is touch" (Toronto, 2001). Harlow (1958) suggests that this importance of touch extends not only to humans. In his classic study of nurturing in monkeys, he found that young monkeys preferred touch over food (Durana, 1998). Infant research demonstrates the large amount of growth that children experience in the early months of their life. This growth occurs well before significant structures in the psyche have developed. Trauma during this time may become lost to symbolic representation, as it is beyond the child's capacities to form representations at this point. In later therapy, this may result in only a superficial response to a verbal interpretation which requires a certain amount of intellectual understanding (Toronto, 2002).

Research suggests a division between transference based on symbolic language and nonverbal transference coming from the body and from early, preverbal experiences. These early experiences are often accessible only through nonverbal channels. Results from studies of touch deprivation in early childhood suggest that it leads to body-based adaptation expressed through body language and gestures. If this is the case, therapists must consider how effective they can be in accessing preverbal or body-based experiences through verbal channels (Toronto, 2002).

Our ideas of what exists outside of ourselves is based on information received from sense of touch, which is mediated by the skin. Humans can live without sight, hearing, taste or smell, but cannot survive without functions the skin is able to provide (Toronto, 2002). The skin provides information about the environment to the central nervous system. Beyond physiological functions, it also functions as an organ that allows an organism to experience touch. At birth, touch is the most highly developed sense and the one on which infants most depend. It provides an orientation to the outside world and generates input responsible for the development of a sense of self. The skin has psychological and social functions as well, allowing an individual to interact in a social world (Kertay, 1993). Touch as a sense implies relationship, movement, and the meeting of inner and outer boundaries. Hearing and sight can be experienced at a distance, but touch requires contact and suggests intimacy (Leder, 2008).

When Words Are Not Enough

The body may harbor deep-set and preconscious modes of 'speaking' through such habits as hyper vigilance and contraction. Language may be an insufficient medium to address preconscious patterns, and difficult to grasp during times of acute distress or illness. Touch may speak in terms the body may better understand (Leder, 2008). Even if insight is achieved it may

not be enough to change a negative emotional complex. Negative affect or compulsive behavior can attach itself to the physical body in a way verbal methods alone may not be able to reach (Greene, 2001). Language can never completely supersede touch, the earlier form of communication. Touch has the power to reinforce, negate, and change verbal messages (Horton, 1995). Occasionally in session, a patient will regress to the point that interpretations will fall on deaf ears. The goal at this point is not to analyze or interpret, but to make human contact in a meaningful way that lets the client know the therapist is present with them in a significant way. Touch can provide that connection (Toronto, 2002).

Effects of Touch in Therapy

There is significant research supporting the positive effects of touch. Massage therapy has been shown to positively effect blood pressure, immune system functioning, depression, and state anxiety. Contact comfort between infants and caregivers has been found to lead to affective bonding, which subsequently impacts a person's relational style for the whole of their adult life. In a psychotherapeutic setting, touch can be used to bring about considerable healing effects (Bonitz, 2008). Research exploring touch used in the therapeutic setting, suggests that touch has restorative and organizing effects on an individual. It can also increase group involvement, awareness of boundaries, feelings of physical and mental closeness, and decreased stress and anxiety. Touch can also have positive effects on growth, breathing, heart rate, and brain waves of infants (Sakiyama, 2003).

The results of recent studies on touch support a considered use of touch with clients who show a need or ask for supportive contact. These findings contradict earlier theories that 'gratifying' a patient through touch will impede the therapeutic process. Rather, touch may help

alleviate shame and tolerate pain allowing them to work through issues more quickly or deeply (Horton, 1995).

Studies conducted by Pederson (1973) suggested touch was related to greater self-disclosure on the part of the client. Studies by Hourard and Friedman's (1970) suggested that clients who received contact also engaged in more self-exploration and evaluated therapeutic experience more positively. Dies and Greenberg (1976) examined touch in a group setting and their findings suggested that increased touch enhanced willingness to take risks, favorable attitudes toward self and others, and enhanced feelings of closeness (Durana, 1998). Bassya (2002) interviewed four psychoanalytically oriented therapists that used touch as an intervention in therapy, examining five cases in which touch was used. Four reported positive outcomes, including integration, relief of pain, increased safety, and grounding in the present moment. In the fifth case the outcome was not known. Horton, Clance, and Sterk-Elifson (1995) surveyed 231 clients who were actively involved in psychotherapy at the time of survey. Sixty nine percent indicated that touch fostered trust, openness, and a stronger bond with the therapist. Forty-seven percent indicated that touch increased self-esteem. Touch was also perceived as a factor that allowed them to feel valued, which helped them to feel better about being in therapy. Therapists report that touch may meet a client's need for containment, affection, and parenting, as well as mirroring content and exploring the unconscious (Phelan, 2009).

Goodman and Teicher (1988) saw touch as helping the client be able to verbalize feelings. Touch can facilitate the release of feelings that are held deeply inside (Phelan, 2009). A number of studies suggest that client's view therapists who use touch to communicate reassurance more positively, though the literature is not universally supportive on this point. Alagna, Whitcher, Fisher, and Wicas (1979) reported an increased positive evaluation of the

counselor experience when touch was used with clients compared to a control groups. Hubble, Noble, and Robinson (1981) found that touch by a therapist resulted in the perception by the client that the therapist was more trustworthy and had greater expertise versus a no-touch therapist. However, there are important elements to consider when studying touch between therapist and client. This one simple intervention is based on a complex relationship between the perceived intention of the therapist, the expectation of the client, and the client's prior experience with touch (Phelan, 2009).

Touch has many potential benefits, but also much potential harm can come from it as well. This can be seen in the sexual exploitation of clients, reenactment of traumatic material, or in the imposition of societal power dynamics such as a male therapist touching a female client who may not feel the agency to protest. There is also the risk of the client misinterpreting the touch, and possibility of fostering dependency (Bonitz, 2008). Further, touch may weaken the therapist's ability to tolerate negative transference from a client (Durana, 1998).

Touch and Culture

Touch as a sense is embedded in cultural expectations and assumptions that influence its meaning in a particular context. The cultural meaning of touch for both client and therapist must be examined. A Latina therapist states that refusing to touch her Latino clients would be perceived as cold and foreign by her clients. In certain countries, like Germany and Switzerland, a refusal to shake hands with a client could be considered rude and insulting (Bonitz, 2008). Though cultural norms are important to consider, it is most important to examine what touch means to each client based on their unique history (Sakiyama, 2003).

Touch in Japan, for example, is viewed quite differently than traditionally viewed in America. Within Shintou, the historical religious core of Japanese society, there are no

preconceived notions that the body is evil and the mind is good. Instead, it is taken for granted that the body-mind is one and that the body is sacred and connected to the gods or sacred spheres. The Japanese recognize the oneness of the body and mind, as the body encompasses not only flesh physically, but also an expanded state of mind, heart and spirit that includes others as well as the self (Sakiyama, 2003). Thus, touch in the therapeutic encounter in Japan is experienced within the context of this history and philosophy, often with the goals of reconnecting people to the shared space and the community. Touch is seen as connecting rather than invasive. Western cultures, rooted in the Judeo-Christian tradition, in contrast can be viewed as touch deprived and individualistic (Sakiyama, 2003).

Therapy embedded in American culture also responds to the cultural norms it lives within. For example, greater touch is reported in female dyads, which reflects general research that shows touch is more prevalent between women than between men (Stenzel, 2004). It has been argued that American culture is also highly sexualized and litigious, which gives therapists a natural caution when using touch. If American culture was more permissive, some have argued touch would be a more acceptable intervention in both physical and mental health settings (Phelan, 2009).

Erotic Contact

Detractors of touch state that although it may not lead directly to sexual exploitation of clients, it is involved in incidents of abuse. Although most touch clearly does not lead to sexual exploitation of clients, such exploitation does take place and should not be taken lightly. Holroyd and Brodsky (1977) surveyed licensed psychologists and found that when all erotic contact was considered, 10.9 percent of male practitioners and 1.9 percent of female practitioners reported erotic contact with patients. These findings were consistent with other studies (Kertay,

1993). Although Holroyd and Brodsky (1977) found that almost one third of humanistic therapists reported non-erotic touching as opposed to 5% of psychodynamic and CBT therapists, the number of sexual abuses did not differ based on therapeutic orientation (Durana, 1988). Holroyd and Brodsky (1980), in a follow up report, reanalyzed their data in an effort to further examine the relationship between erotic and non-erotic touch. They found that therapists who differentially touched opposite sex patients were at higher risk for sexually offending. Thus, the therapist's attitude toward touch was a significant issue contributing to sexual abuse of patients (Kertay, 1993). More recent surveys (Pope, 1990; Stenzel & Rupert, 2004) indicate that sexual contacts between therapist and client have been reported less and less as time goes on. However, this trend may not reflect an actual decrease but also more awareness of ethical and legal penalties which cause practitioners to not report instances of abuse (Bonitz, 2008).

How to Decide to Touch

Given the potential benefits and risks, what considerations should a therapist take into account before deciding to touch a patient? Touch can soothe a patient who is distressed, but care must be taken to make sure the touch does not soothe the therapist instead. Generally, therapists must be clear about their motivations to touch and be willing to take full responsibility for their patient's and their own reaction to the touch. Ongoing supervision or peer consultation is advisable (Kertay, 1993). Practitioners who decide they are not comfortable using touch should make this clear to the client, so that the client may avoid shame for any need for physical contact. Since therapist's attitude toward touch has been linked to abuse of clients, a considered and thoughtful inventory of therapist's intentions and attitudes toward touch is essential (Horton, 1995).

What situations suggest touch might be beneficial? Caldwell suggests therapists touch when they want to convey symbolic mothering, acceptance of the client, to strengthen a sense of reality when a client is threatened by anxiety, and to help with regulated expression of anger (Phelan, 2009).

If touch is used often, or as a formal intervention, there are those who recommend a thorough training in body awareness that uncovers practitioners own blocks so they are not communicated to the client. This enhances respect for boundaries (Greene, 2001). Though personal experience of touch in the therapeutic encounter can beneficially inform a practitioners' view, adequate theoretical and technical skill are also advised to proficiently and ethically apply this technique (Stenzel, 2004; Phelan, 2009).

Which Therapists Touch?

There are significant differences between therapists who use touch and those who do not. Humanistic therapists are more likely to touch than CBT or psychodynamic therapists, female practitioners more likely than male. Also, therapists who consider touch to be healing, who have had positive experience of touch in their own therapies, those who have received training in touch, and those who had supervisors who supported its use are all more likely to touch their clients (Bonitz, 2008).

When therapists were confidentially surveyed, high percentages revealed they used touch and found it to be a successful component in their work. Tirnauer, Smith, and Foster (1996) reported that 87% of therapists reported touching their clients. Other studies found 85% of practitioners hugged their clients (Pope, Tabachnick, & Keith-Spiegel, 1987); and almost one third of psychotherapists in another study stated they utilized some form of touch with their clients (Holroyd & Brodsky, 1997). Strozier, Krizek, and Sale (2003) reported that 95% of the

social workers who responded to their survey stated they had used touch with clients at least some of the time, and 29% used touch often or very often. The types of touch examined in these studies were diverse but included handshakes; touch to the arm, shoulder, and neck; hugging; holding; stroking; and patting. A survey that included 470 practicing psychologists asked about their touch behaviors during session. Almost 90% never or rarely touch clients during therapy. The handshake was the only form of contact that occurred with some regularity. When touch did occur, typically it was not discussed (Stenzel, 2004). Wilson (1982) found in his work that many clinicians used touch, but did not seem to trust the professional dialogue enough to be able to participate in it. This, in addition to the variances due to profession or theoretical orientation, could explain the variety in numbers of clinicians who report touch (Phelan, 2009).

Who Benefits from Touch?

There are some populations that seem to have a better response to touch than others, and some populations where touch would not be indicated. Schizoid clients with bonding and attachment deficiencies often respond well to touch. Clients that function highly but mainly at an intellectual level can benefit from therapeutic touch, as well as clients who think a need for closeness is shameful (Bonitz, 2008). Patients who identified sexual problems, a history of sexual abuse, or fears and phobias saw touch much more beneficially than those who did not identify these problems (Horton, 1995). Clients that have issues of engulfment or a history of poor boundary control are not recommended for touch as an intervention (Bonitz, 2008).

Using touch with clients who have a history of physical or sexual abuse is debated. Touch might result in reenactment, violence or dissociation, and further trauma. However, abuse survivors who experienced touch respectfully and appropriately during session reported

therapeutic benefits. These benefits included trust, self-esteem, an opportunity to set limits, and an experience of touch that was not violent or sexual (Bonitz, 2008).

The question of who benefits from touch in therapy has rightly been put to clients who experience touch in therapy. Receiving touch in therapy is a mutual partnership, not just one party passively receiving the action of the other. The patient must actively receive touch, allowing the clinician to guide them in a process they may not be able to achieve alone (Leder, 2008). Geib (1998) found four recurrent themes associated with a client's feeling that touch was helpful. The four themes are: the client has a sense of being in control of the contact; it seemed to respond to their need and not the therapists; the touch was verbally processed after it occurred; and the touch was congruent with the overall level of intimacy already established between therapist and client (Leder, 2008).

Some studies indicate patients find it difficult to ask for touch and to express negative feelings about the therapy. Generally, touch is perceived positively when there is enough depth in the therapy relationship to openly discuss the relationship as it is occurring, or to relate thoughts and feelings about the therapist to the therapist. Such an act requires openness, and is not something that can be readily expected. Ironically, touch may play an important role in helping to reach such openness by affirming the relationship and allowing the patient to take deeper risks. The inability to speak openly with the therapist about the relationship is linked to negative perceptions of touch. Even if the touch is initially perceived as positive, inability to later address potentially negative reactions was linked to negative reports of touch overall. Not surprisingly, then, patients that ranked high on scores of therapeutic alliance were also ranked highly on perceptions of touch (Horton, 1995).

Though there is no firm agreement in the literature, studies have supported using touch with the following clients and at the following times; suicidal crisis, psychotic breakdowns, grief and trauma, anxious and severely depressed clients and the elderly. Wilson (1982) notes touch is used best during the working phase and during crisis points, but is also appropriate during termination to express love and celebration (Durana, 1998).

Why Does Touch Heal?

The importance of touch as a sense and in human development has been well documented. But what about touch exactly gives it the potential to heal, and what gives a practitioner “the healing touch?” Touch as a medium can create a close embodied dialogue. In the end, it might not be something the clinician or the patient does, but something that unfolds in the space between, and supports the space that contains it (Leder, 2008).

Remen, an American medical doctor surveyed by Moyers (1979), observed:

You know, touching is a very old way of healing. We don't touch each other in this culture, and touching is often misunderstood or even sexualized. As a physician, I was taught that you touch people only to diagnose them, and if you touch them in any other way, even in a comforting way, they may misunderstand. And yet, touch is the oldest way of healing. Touch is deeply reassuring and nurturing (p. 355) (Sakiyama, 2003).

There has been a reluctance to speak about touch in traditionally oriented psychotherapy due in part to the historically taboo nature of the intervention. However, it can also be attributed to the practical difficulties of accurately describing and capturing the gestures, postures, and sounds that therapists use that move therapy further. And yet, not discussing what occurs in therapy is a likely way to increase the kinds of boundary violations the profession needs to avoid. It also denies therapists access to information about potentially beneficial tools (Toronto, 2002).

Breckenridge (2000) holds that nonerotic touch is 'no more inherently problematic than any other type of relational interaction in psychoanalysis' (pp. 19-20). Due to its importance as a human need, the strict avoidance of it is not neutral but rife with meaning. The absence of emphasis on bodily experience, of either patient or therapist, has been so striking as to garner charges of defensiveness (Toronto, 2002). In light of all the potential growth associated with touch, thoughtlessly denying it can put treatment and patient at risk (Phelan, 2009).

Touch, Horses, and Therapy

Rhythm

Hirai (1996) found a relationship between rhythm used when applying touch, and feelings of ease. Patting an individual on the shoulder was more effective in helping subjects feel more comfortable than maintaining a consistent touch. This was examined through heart rate of the subjects. The patting rhythm also brought on affective states more pleasantly and energetically. The data indicates that patting also helps people feel more comfortable in groups. Other researchers support the relationship between rhythm and movement as a powerful potential for evoking emotions (Sakiyama, 2003). Rhythm is a fundamental building block of all schools of riding. In the hands of clinician skilled in mental health and riding, rhythm could be used as a powerful tool to guide a session.

Body Congruence

Dissonance between spoken and non-verbal information is an important window into the mind of the client and the transference. This dissonance speaks for the therapist as well should they hold such dissonance. The body stance of the therapist, whether it be a sleepy look, folded arms, or a pointed finger can express as much if not more than carefully chosen words. If the therapist's body and words do not match up, this can be a source of confusion and alienation for

clients attempting to relate to the therapist (Greene, 2001). It has been suggested that, due to their nature as prey animals, horses have the ability to reinforce congruence in humans between the spoken word and body language. They do this by portraying with their own bodies their reaction to those around them. In this way they can act as a mirror, reflecting a person back to themselves (Vidrine et al., 2002). The potential benefits of this mirroring as a therapeutic tool in therapy are only beginning to be explored and documented.

Support for therapeutic methods that work with the body has been increasing. However, many of these newer methods do not access the insight and interpretation available in the so-called depth therapies. Those who practice depth therapies could expand their methods to deliver a more wholistic approach by deliberately including the body (Greene, 2001). A blending of therapies that provides access to historically developed approaches, while including the body in a direct experiential way that can include touch, is what this study is seeking to clarify through its examination of touch between a client and a horse in a session guided by a professional mental health clinician.

Chapter III

Methodology

Research Design

The hypothesis of this study is that touch in the therapeutic encounter will be a valuable and unique aspect of equine facilitated psychotherapy (EFP). The aim is to find out from clinicians exactly what benefits or drawbacks they see from the use of this technique. The research method is qualitative and the study is exploratory in nature. A semi-structured interview will be employed to question 13 clinicians or professionals who are currently practicing or have practiced EFP. Each interview will last approximately 45 to 75 minutes in length, and will be designed to thoroughly explore the clinicians' observations of the importance of touch to EFP. The interview will specifically concentrate on the clinician's views of touch generally in the therapeutic encounter, as well as within this specific modality. The interview will examine what results they have achieved through this intervention, and with what population and in which specific situation or phase of treatment. Finally, the clinician will be asked how important they think touch is to EFP and if touch within this modality differs from touch in other therapeutic circumstances. The interviews will be recorded, transcribed, and analyzed for themes. Each theme will hopefully more fully elucidate the potential uses of EFP, as well as areas for further research.

Internal validity in this study will be questionable as there are many factors that may affect the therapeutic encounter besides touch. By focusing on one variable, the hope is to add more specific knowledge to this growing field about an aspect of this therapy that is unique. By

closely examining the perceptions of clinicians concerning this particular aspect of the therapeutic encounter, this researcher hopes not to establish causal relationships, but rather to suggest areas of further research.

External validity shows similar weakness. This study is not generalizable. Due to sampling methods this study will not examine the observations of representative sample of clinicians, nor the experience of the client's themselves, nor specific outcomes of therapies that use human-equine touch compared to those that do not. Rather, it will reflect more accurately clinicians who self-select to participate in this interview, and their particular views. However, it is hoped by examining 13 individuals, the themes that emerge will point to larger trends more generally consistent with the combination of EFP and equine touch. A future study, based on these findings, could further elucidate the trends and strengths of this form of therapy, perhaps suggesting specific populations more likely to benefit from what it has to offer.

Sample

The sample must be clinically qualified and a current or past practitioner of EFP. Clinically qualified is defined as practicing therapy as defined by the laws of their state of residence. The educational background might vary to include an MSW, LCSW, LADAC, LMHC, or the variations of these degrees as specified by state regulations. They may work for an agency or be in private practice. They must speak English. EFP is defined as psychotherapy that includes the horse, and would be considered therapy if the horse was not present. Further, these EFP sessions must include touch, or physical contact between the client and the horse. This touch may take the form of riding, grooming, or groundwork but must include contact with the animal. Exercises that include herd observation, general horse care or stable management will not be considered sufficient for inclusion in the study.

This is a non-probability sample, gathered through convenience sampling and snowball sampling. This researcher had the names of two clinicians who fit the criteria through past employment experiences, and gained their consent to participate in the study through email. During the course of the interview they were asked if they knew other clinicians who would be willing to participate. They indicated that they did, and asked the researcher to forward them an email describing the study, which they then forwarded on to their contacts who could then contact the researcher directly. Several people did contact the researcher, and also forwarded the email on further to people they knew, and some of these persons contacted the researcher. In this way, through snowball sampling, the sample size of 13 was reached.

From this sample, all are female and 12 identified as white. The ages ranged from 28 to 73, mean age being 51.5. All identified as American citizens. Years of professional experience ranged from 5 to 39, average being 17.1 years. Clinicians described using several modalities including CBT, narrative therapy, EMDR, reiki, cranio-sacral work, psychodrama, and family systems work. Seven were licensed social workers, 2 were licensed mental health counselors, 2 were psychologists, one a psychiatric RN, and 2 had more than one degree in mental health. The thirteenth participant holds a certification as a lifecoach, and was included after a brief discussion as she meets all other criteria. However, this was done with the understanding that 12 participants needed to obtain a valid qualitative sample did have strictly clinical backgrounds. The first 13 who contacted the researcher who fit the criteria for the study were selected.

Data Collection Methods

The data to be gathered is the responses of the clinicians questioned about the importance of touch to the therapeutic encounter experienced in EFP. An audio recording device will be in the room where the interview takes place to do this. The interview will be semi-structured, with

a set of questions to be covered in a flexible order, with an emphasis on using neutral probes to further encourage clinicians to share their observations.

The interview itself should not by design touch on any sensitive or potentially harmful information. Rather, it should focus on the clinicians' professional opinion and experience of a particular therapeutic technique, and an evaluation of this technique. The clinician's participation in this research is kept confidential, as well as the information they share. This study was approved by the Smith School for Social Work Human Subject's Review Board to ensure that the rights of all participants would be protected. Participants are told of their rights as participants and asked to sign an informed consent form detailing those rights. They are also told of their right to withdraw from the study by April 15th, 2011 and given an opportunity to ask questions.

Once a sample size was reached, a location for the interview to take place was negotiated. If it was feasible for this researcher to travel to interview in person, that was done. However, in several cases this was not possible and interviews took place over the phone. These interviews were recorded with the program Google Voice and access to those files was password protected.

Each interview was transcribed by this researcher and analyzed for major themes. Commonalities will be pulled from different clinicians to suggest more general themes and applications for EFP. The possibility of misinterpretation would arise in the faulty analyzing of data or in the asking of inappropriate or leading questions.

Data Analysis

The collected data will be coded by theme and participant. The data from each participant will be analyzed for themes using open coding. Once each interview has been coded, the data under each code from all interviews will be pulled together and synthesized once again

to further refine themes. Any theme occurring in more than 6 interviews will be considered a major theme, while any theme occurring in more than 3 interviews will be considered a minor theme. As an exploratory study, it is hoped that these themes will point more generally toward the efficacy and potential of the use of touch in EFP. By bringing all themes from 13 professional together, the hope is to more fully answer the question, what does touch between human and horse mean to EFP?



Chapter IV

Findings

After conducting 13 semi-structured interviews, each interview was coded for themes. The themes were then gathered together from all interviews under one document and analyzed again for major or recurring points within that theme. The themes and major points found using this process are listed below, followed by representational quotes to support each theme. The number of times each theme was referenced, as well as the number of clinicians who spoke about a certain theme, is listed next to each heading.

Every participant in the sample self-identified as female and American, and with one exception white. This woman identified herself as Eurasian. The sample included no men, and no practitioners under the age of 29. Due to the small sample size and convenience sampling techniques, these findings are not generalizable to all practitioners of this therapy. However, these findings can offer a view, a window, into the possible ways in which one specific technique within a specific form of therapy is viewed by some of the people who practice it.

There were twice as many secondary finding as primary findings as measured by number of typed pages. Secondary findings are defined as those not specifically related to the original research question but still relating to this particular form of therapy. This could be for a number of reasons. First, as the field of EFP is still young general questions might be more expected and practitioners versed in that vein rather than on focusing exclusively on one particular technique. Secondly, either the interviewer or the interviewee might have shown discomfort, boredom, disinterest or resistance to the topic due to the potentially polarizing nature of touch within the

therapeutic field. Thirdly, there could have been errors within the interview process itself in terms of the same questions not being adhered to or administered in a leading or unsound manner. Despite these possibilities, practitioners did come together to produce 25 major themes that did suggest some consistency and durability when discussing their observations of equine-human touch in a therapeutic setting.

Primary Findings

There were 11 major themes involving touch and 2 minor themes. The major themes are:

- 1) Involvement of the client's body
- 2) Possibility of differentiating touch for client
- 3) Safety of equine-human touch (EHT)
- 4) Movement of riding
- 5) Clients need to touch horse
- 6) Calming effect of EHT
- 7) EHT as connection
- 8) Horse's ability to touch a client in ways a clinician cannot or should not
- 9) Clinicians touch their clients with more frequency when horse is around
- 10) Clinicians plan EHT as a specific intervention
- 11) Clinicians discuss touch (between themselves and client and EHT) more in barn.

The minor themes are

- 1) Control over touch
- 2) Horses provide a physical holding environment.

Each theme will be examined in more detail below.

Major Themes

#1 The involvement of the client's body: 42 references, 12 clinicians

As somebody who's worked in mental health for 25 years I've seen that we've progressively left the body out of the healing equation more and more and more. And so really the only way the body kind of gets involved in therapy these days is becoming a vehicle for med administration.

This theme can be broken down into three main parts: EFP is an active therapy involving movement and physical change of space, EFP can easily target sensory integration issues, and EFP can utilize sensory experience to put a client back in touch with their own body. Survivors of abuse were particularly referenced in this section. Clinicians noted that the physical, sensory experience of the barn could "activate their [the clients] psychomotor systems a little bit and give them a little, add some good serotonins into their system, provide a little relief and joy for them." Especially in reference to children, four clinicians noted that being outside, moving a client's body and moving location, seemed to aid in the therapy.

One clinician noted a sensory exercise she developed specifically for survivors of abuse that involved EHT. This gradual, step by step exercise was designed to bring dissociated or shut down clients back to their body, and involved smelling the horse, touching the mane to the client's face, and touching the horses' face with the hand. One clinician reports "one participant of this exercise just began crying in the stall and of course I went in to talk to her and she said that this was the first time she had been able to feel her body since the rape and it just felt so good to her to be back in touch with that and it was a real opening and healing moment for her." Another clinician states

We know that touch is essential to development, that's not a theory that's been proven many times. Whether it's the Romanian orphans that were permanently brain damaged and did not develop because they were not held and did not receive appropriate physical stimulation, or whether it's someone who's muscles atrophied after they've had an injury or because of disease, parts of the body and the brain only develop when they're stimulated you know at the neuronal level. Touch is essential for typical neurobiological development. So experience with horses can absolutely assist with that, especially in somebody who's been medically compromised, you know developmentally either has a disorder or delay.

Touch from a horse could be used to awaken a depressed client, or one shut down from trauma.

Touch could also be used to take a client "out of the intellectual mode and into the body in a way that talk therapy really doesn't." This allows for repressed feelings to surface with more ease, and a visceral sense that clinicians felt stayed with a client perhaps longer than verbal interpretations alone might. While riding, a client's body might also be positioned not only for correct and safe riding posture, but also to challenge or reveal embodied attitudes. One clinician describes a high-achieving client who struggled with an eating disorder. She states

She would ride the horse all hunched over like you would a bike, and it took us probably five sessions to sit up straight. But in the process of that she had to let go of some things...she had to let go and trust the horse, myself and the assistant...and as she started to do that, it probably took 6 riding sessions but she was able to do that, sit up straight pretty much. I felt it was a real letting go for her, it was a trust thing.

Not only are emotional patterns noted and explored verbally, but they can be seen in the client's body, and new methods can also be enacted in the client's body to further integrate the healing process.

Sensory stimulation is readily available at the barn, partially through the touch of the horse. One clinician notes "I think kids with sensory issues find the touch of the fur very very soothing, I think it feels very nice to them. A lot of them don't want to touch the mane though. The mane is much more coarse but they do love touching the body." Through the available stimulation a clinician can guide a client to areas that soothe as well as challenge, and help a client learn how to meet and handle these challenges. A clinician notes "as we're working with the child we'll pick up on what their challenges are, and then go from there. If it's a child who's always overly startled 'I don't want him to scream again' we'll explain the reasons behind the whinnying helping the child to make sense to understand the reasons, why the pony is doing things, its not just to startle the child...and that helps for most kids." Another clinician notes "I think that for kids who are autistic or have other sensory touch issues paying attention to that with the horses or paying attention to what they like or don't like can help them to know what they do or don't like." In this way, clinicians use EHT to challenge, soothe and educate a client about their own sensory challenges and needs.

"There is so much of this [trauma] and it collects in the body...And body work is important, if you know what you're doing in very strict clinical situations."

#2 Differentiation of touch: 9 references, 7 clinicians

The horses body can become a laboratory to explore what kind of touch is appropriate. One clinician notes " this particular girl did a great job of discovering my gelding doesn't like soft touch he likes firm touch. And we explored that, how do we know he didn't like it, he kinda

moved away. And when she gave him good firm touch he just kinda settled into it. So we looked at those kinds of what is the kind of touch, what is the quality of the touch that's ok."

Touch that is acceptable to the horse can broaden into a wider discussion of boundaries in general. One clinician notes "and sometimes they'll touch them too hard or they'll brush them too vigorously and you know working on appropriate or positive touch." A second clinician notes that clients, especially those with autism, might slap or pinch a horse "and those aren't connecting ways of touching you know? So I feel that some kids have to learn at least this, and then you hope the rest follows." Learning to appropriately touch a horse can also open the door to empathy as well as boundaries. One interviewee states

And a lot of people I work with need boundaries, so touching or non-touching or appropriate touching is a real good way to teach them boundaries. And it's a good way to use the horse because there's places a horse doesn't want to be touched either so you teach them to respect the, you don't just touch them there because you feel like, you have to think about how the horse feels about it too.

Exploring different types of touch through the horse's body enables clients to implement limits as well as open a focus onto empathy, should the clinician deem those focuses necessary.

Touching a horse can also "help them understand that there are positive touches and painful touches...how they can be assertive without being mean." This can be especially helpful to clients who have experienced trauma. As one clinician notes "and for those who have experienced bad touch it can help them to sort of have a corrective experience and to be able to distinguish good touch from bad touch be able to set boundaries and limits and have control over good touch versus bad touch to be able to sort of reawaken themselves at a somatic sensory level, to enjoy good touch because they have been so shut down." Although EHT can have many

benefits in the hands of a skilled clinician, caution is warranted. Clinicians note that “touch can mean different things to different people” and “I think the horse is an extension or metaphor for the therapist often, and I think you have to be extremely careful about what and how that child or adult is interpreting that touch.” This warning is only compounded by the sometimes complex and layered nature of EFP. One clinician notes “you have no clue, lets say you’re doing work and you have an equine specialist who happens to be a male and you’ve got a female patient, a young adolescent girl who may have a crush on this guy...the touching of the horse could have a whole other meaning you’re not even privy to.” Although the potential for the differentiation of touch can be healing for a client, misinterpreting that touch has the potential to weaken the therapeutic alliance and cause misattunement and thus care must be used when arranging EHT as an intervention.

#3 Clinicians plan EHT as a specific intervention: 9 clinicians, 12 references

When asked if they viewed EHT as a specific intervention, or planned it as such, nine clinicians responded that they did. In addition to the sensory-awakening exercise described above, one clinician notes “with women who have been sexually abused I will mount them on a horse with a bareback pad so there’s a lot of contact in that intimate area and that will often provoke a lot of emotional discussion, reaction and discussion, opportunity for discussion. So those are two times that I very specifically say touch is what I’m after here.” Another clinician states “I want them touching that horse, I want the sensory input, the connection.” A third clinician stated she planned touch specifically when thinking of clients with sensory integration challenges. These clinicians seemed to be very aware of EHT and to use it often in their sessions. Further, 8 clinicians stated that it would not be possible, or would be very limiting to

practice EFP without EHT. One clinician stated simply “I suppose you could, but I wouldn’t want to.”

#4 Safety of EHT: 30 references, 10 clinicians

When clinicians stated EHT was safe, they had four basic ideas in mind; 1) EHT is genuine, objective, and believable 2) EHT is non-judgmental 3) It carries no social pressure and 4) EHT is nonerotic contact. The idea that horses “don’t come in with opinions about the people so that there is a safety” was repeated several times. Thus, when a horse reaches out to nuzzle a client, that affection can be seen as more genuine than a therapists “because the horse ain’t gettin paid to do that.” In turn, when a client reaches out to touch a horse this gesture can also be seen as more genuine. A clinician notes “and everything that the client does in touching the horse we know for sure just comes from the client. There’s no concern that they might be feeling, like from a human they might be feeling pressure to accept a hug. With the horse its all just coming the from the client, so you know its coming from their heart and its sincere and they’re not responding to any kind of pressure.” This seems to encourage an honesty between client and horse that might not be so easily applied to client therapist touch interactions. Clinicians also saw the fact that a horse cannot sexually abuse a client as a piece of the safety around EHT, and also a part of their enthusiasm as clinicians for prescribing it. One clinician notes “the kids realize ‘oh he’s not gonna hurt me he’s really safe this is a safe animal and I can allow, I can touch them and I can allow them to touch me.’” The differentiation between erotic and nonerotic touch is quite stark with the horse, while much murkier with the therapist. One clinician saw this as a cultural critique, noting other countries were much freer with touch than the United States.

Ironically, though 10 clinicians referenced the safety of EHT 30 times, 9 clinicians referenced harmful touch coming from horses 32 times. This touch could come in the form of biting, bolting, rearing, kicking, snapping, nipping, stepping on clients, or spooking. One clinician noted the reins pulling through a client's hands and hurting her; "yeah, I think that was her last ride." However, clinicians do not see this physical danger as all bad. A clinician notes "the horses also have their other touch which is actually very educational for people who have great difficulties of their own with boundaries." Another clinician describes a time her horse reared with a client: "at first the client was like 'yeah I'm ok that was different that was cool' but then later she was able to say 'that was really scary' and I was like 'yeah that was really scary' and it was a real moment for her." The safety considerations inherent in protecting the client as fully as possible from potential physical harm, according to many clinicians necessitated additional physical contact between the client and themselves.

**#5 Clinicians touch their clients with more frequency in the presence of the horse:
10 clinicians, 13 references**

Seven clinicians noted that, although their personal rules for touching a client, such as asking permission, did not change in the barn, the nature of the work often necessitated that they touch their clients with more frequency. This included assisting with mounting, dismounting, and sometimes using a hand-over-hand technique to demonstrate a specific skill such as grooming. Clinicians also note that when instructing how to ride they may touch a client's leg or back to educate them in the correct posture. Safety considerations such as horses spooking quickly may also necessitate that the clinician push a client or move them quickly out of the way of danger. Beyond practical considerations, four clinicians noted that the informal atmosphere of the barn also made touch seem more appropriate. One clinician stated "and it's a much more

informal setting that touch really seems more appropriate.” Two clinicians noted the lack of sterility, and two clinicians noted an increased feel of intimacy. She states “I don’t know if its because they’re touching the horse so they feel more comfortable like having your hand on their shoulder or something like that. I dunno it just feels like a more intimate situation. I don’t think its so much drastically more.” Though there may be more contact between client and therapist for reasons of safety, practicality, or because of feelings of informality and intimacy, the rate of how much more clients are touched, their feelings about it, or the effects on the therapeutic encounter were not explored.

#6 Horses can touch clients in ways I can’t: 14 references, 7 clinicians

“The equine, at that point, really becomes a conduit, and can tap into so many issues that have to do with touch, and I think it’s a really valuable part of the experience.” Clinicians also noted that the horse could provoke psychological issues, and elicit material in ways that they as clinicians were not capable of doing. Riding was mentioned as a physically intimate act that set horses apart from not only clinicians but from most other therapy animals. A clinician notes

That’s actually one of the reasons I choose to work with horses because I feel they’re a much better, they’re a surrogate, for that touching relationship. They can have a much closer relationship in terms of physicality than I can appropriately have with a client, so that’s one of the real benefits of working with horses is they can go places I can’t go.

They can touch clients in ways I can’t. They can have a physical intimate relationship with the client that I cannot.

Again caution was advised as this closeness and intimacy can lead to vulnerability, and “the movement of the horse can trigger issues...and you never want a child cracked open before they

can handle what may come of that.” The titration of this intimacy and physical closeness must be taken on by a skilled clinician, and with the full participation and knowledge of the client.

#7 Movement of riding: 22 references, 10 clinicians

The pairing of touch with the rhythmic, repetitive motion that is riding made three clinicians think of EMDR and the possible relationship between the two. The movement of riding was also viewed as calming and settling. One clinician notes “if I can get her on the horse and just the motion, just so settles her” and “his one hour session always starts with a ride on the horse because the movement of the horse helps settle him down, and helps him organize so then we can do something productive with the second half hour of the session” or “in terms of riding you know they’re getting that feedback through they rhythmic movement of the horse which can be very calming to a lot of children.” Riding was also seen as helping clients talk more easily in 5 references. There was one counter-reference in which a clinician noted that clients often opened up spontaneously while grooming their horse, and rarely while riding. In this program, however, the clinician does not teach riding but the groundwork, while in all other references the riding was overseen by a clinician. Other clinicians used trotting with autistic riders “to get a genuine laugh you know that’s exciting” or to help ADHD riders focus and to contain themselves.

#8 Clients need to touch the horse: 12 references, 7 clinicians

Many clinicians saw clients as being drawn to the horse and feeling a pull to touch them. One clinician noted “and I think a lot of people have companion animals in order to experience touch.” Their name, a pet, lends credence to this theory. Clients stated “these exercises happen a lot because people need to touch the horse” and “because the kids do love to touch the animal, they do. They don’t want to touch a person, and they don’t want a person touching them, but

they do want to touch that animal.” One clinician told of clients “who sort of self-prescribe touch and we have these sort of individualized arrangements...like I have one client who really needs the contact of bareback and really benefits from it and requests it.” Another client who runs workshops notes that her workshop participants are “people who stop by the roadside longingly by some fence or other to get contact, just contact, there’s this yearning in us to have contact with horses. People are so drawn to touch the horse and to want to contact them.” One professional notes that some people are afraid, have had a bad experience or are just not interested but “most people are very curious though.” This same professional notes “that the first thing people do when they approach the horse is to raise the hand to start touching.” She describes an exercise in which she deliberately forbids use of hands, “but as soon as they’re given the go ahead” clients again raise their hands to contact the horse. Child therapists observed similar reactions in their clients; “I think for a lot of kids they just wanna sit there and either touch or hug the horse” and “our mini is so little and cute that the kids just want to touch him all over” or “I think the kids really enjoy coming because they enjoy touching the horses they enjoy working with them.” Those therapists who had more animals than just horses noted that this desire was not exclusive to horses; “the kids really crave being able to touch or feel or work with the animals, not just horses.”

#9 Touch is calming: 28 references, 11 clinicians

Clinicians noted that clients breathed more slowly when working with the horse, and reported decreased anxiety and feelings of peacefulness. Two clinicians noted the rhythmic motion of both grooming and riding as adding to feeling of peacefulness. Clinicians noted that clients tended to be more open because they seemed more relaxed; “other kids, if I see that they’re calmed and just, I think the repetitive motion and just being able to touch the horse seems

to ground them, make them feel safe, I'm not sure what it is, but yeah I found that kids are relaxed and will share more information." Clinicians described exercises of leaning on the horse and matching their rate of breathing to the horses to further feelings of relaxation and grounding. They noted that this touch had an effect on both sides of the equation, and that the horse was also often calmed and soothed by the touch of the client; "it's funny, they all say that its very calming but some of them mean that when I touch the horse it calms him down, and I often have to clarify that with them, and then get to well what does it feel like for you when you touch the horse, And then they are able to tell me yeah I think when I touch the horse it makes me feel good, too." A professional notes that the horses role of receiving touch is not merely passive; "there's a way that the horse just allows, it's a giving of the horse to that touch, too, so that the horse is allowing that, inviting it, and its safe and its from a tactile perspective its soothing, comforting." Clinicians noted that they sometimes paired somewhat anxious clients with somewhat anxious horses so clients could face their anxiety and then experience a positive spiral of success when they were able to relax and calm their horse. A clinician states "so if we can teach them to relax when they're on the horse that makes the horse more relaxed which then makes them more relaxed which then has they'll have a better ride and then they can start to see how when they relax just in general things go better for them."

#10 Discussion of touch, between client and horse and client and therapist, occurred with more frequency: 8 clinicians, 14 references

Eight clinicians noted that they do not discuss touch with a client unless they feel there is an issue or that it is clinically indicated "it's not something we talk about a lot." One clinician stated she would shake hands, hug if they ask, but tries to avoid touch if possible. A second clinician stated that touch between client and therapist "is generally incredibly inappropriate, but

there are some exceptions.” Another clinician noted regional differences “well I’m in the South you know so people hug a lot so if they initiate a hug I’ll hug them, and if it’s a client I know well I might reach out and pat them if they’re distressed.” Clinicians often noted themes of asking permission, assessing for non-verbal cues of comfort or discomfort, and warning a client before they touched them after gaining permission to do so. However, it was not often a topic of discussion.

When working with horses, clinicians noted that not only did they touch their clients more, and the clients touched the horse and the horse touched the client, but that they needed to discuss touch more. This included touch between themselves and the client, and touch between the horse and the client. Six clinicians noted specific exercises they did to introduce EHT to a client; “how do you move into touching a horse? How does a horse permit you to touch? How does a horse touch you?” and “and then I would teach the person how to introduce themselves to the horse...then I would show places the horse likes to be touched” or “we’ll talk about when you’re approaching the horse and touching horses and where do they like to be touched...we’ll talk about touch in terms of being polite...being polite to horses is important and touch is one of the ways we’re polite to them, paying attention to what kind of touch they like and what kind of touch they don’t.”

Clinicians needed to discuss touch between themselves and the client for reasons of safety, particularly in terms of an emergency; “in an emergency situation I might have to put my hands on my client to move them quickly and without permission, and we talk about that.” Clinicians noted that they talked about the purpose of their touch with clients, and were willing to negotiate with clients if safety and comfort became an issue.

#11 Touch equals connection: 13 references, 7 clinicians

The result of a client touching a horse is that they form a relationship and connection to that horse. One clinician notes “it [touch] is a part of connecting with them, and it allows them that connection on a different level than if they don’t touch them...touching can so deepen that relationship and make a difference in it” and “the good news is that as humans we seem to be able to connect without touch, but I do believe that touch accelerates the connection and deepens it” or “well its always about the relationship and the relationship is about connection and the connection is about the touch.” A lack of touch would lead to a lack of connection as one clinician notes “I believe you really need to have them touch, otherwise its as if the kid is just sitting in a chair or sitting on a bicycle, like they wouldn’t be connected.” Touch can lead to “there’s a more direct connection” between client and horse. One clinician describes a young girl who was selectively mute and “I think touching was her first way to communicate with the horse, and then she started using her voice, but it was, it broke down a barrier for her in a good way.” Another clinician notes “being able to touch the animals you’re already instantly building that kind of relationship with them” and “being able to groom the horse, pet the horse, I see such emotional connection between the kids and the horses.” The touch can lead to connection which in turn builds a relationship which can then bring about the change desired by the treatment goals. A clinician states “I think it was Yalom who said that relationship building was the one thing in therapy that creates the most change, and I feel like by them establishing their relationship with the horse through touch that can kind of strengthen the relationship and can also bring change for some of the treatment goal’s they’re working on.” The relationship with the horse is seen as a place of connection and potential for therapeutic change, and that place was formed at least in part by the ability to exchange touch.

Minor Themes

#1 Holding environment: 10 references, 5 clinicians

Clinicians described horses, particularly mounted work, as being able to provide a physical holding environment for client's who had perhaps not received 'good enough' parenting. One clinician describes an exercise in which they used the horse as a metaphor to carry her through difficult periods in the client's life. She notes "generally once we get past 8 or 9 we're not gettin carried around very much. It was really helpful to be 'carried' through those difficult things. So that was a way we used the mounted work and the support of the horse and the touching and the warmth." Other clinicians noted "I do think that the client sitting on the horse and the horse taking care of them and holding them I think that's huge" and "I think that is one of the strongest places and roles that horses, especially riding, plays a role in, because a horse is physically carrying the client and that can be a very corrective experience for the client." She goes on to note "I think that there really is a correlation between the physical holding of a horse and the physical holding of a parent." By carefully arranging scenarios where the client can feel assisted or carried by the horse, some clinicians see a correlation to the maternal holding environment in a very basic, physical sense. One clinician notes "I think it was Erin Catcher who first pointed out that the size ratio of horse to human is very similar to that of mother to infant. So if you go back to a lot of the really basic theories of early childhood development and disrupted development you can look at the literature on creating a holding environment. That is what horses do for people a lot of the time in a very basic sense" and "there is a very primitive attachment between people and horses and animals in general." Clinicians also tell stories of loose horses in an arena forming a ring around a client to 'hold space' for them while they talked.

One professional notes that often a client will stand and stroke a horse while talking about something difficult. She states that during those times “there’s a way that I think it lets down a guard and opens up a vulnerability at an unconscious level to let that love in. That feeling of safety and the power, a lot of it is unspoken.” Another clinician describes a scenario in which, after about 5 months of introductory work, she would have a child mounted on a pony laying across his back and neck, while she was led around the arena at a walk. At the same time the clinician would have her hand on the middle of the clients back and she and the equine specialist would sing to the client. The clinician describes the client; “and she would just zone out, just as a child does when they’re suckling a mother’s breast or snuggling in for an afternoon nap. This is something this child never ever had, and the pony was able to quote unquote hold her while she was able to take in pleasurable, soothing, deeply nurturant aspects that as I say this child never had.” This clinician describes another client “and again it was one of these soothing kind of situations where the child could then begin to take in good enough mothering a la Kohut and to start to build a sense of self. How else do you do it? You know with a little child you’re mothering them, in a clinical situation.” The horse acts as a surrogate parent in that it can create a physical holding environment similar to a parent rocking a child. Clinicians described how they would utilize this ability of the horse particularly with clients who had experienced trauma.

#2 Control over touch: 8 references, 5 clinicians

Clinicians noted that part of a healing, empowering process for a client involved having control over the touch they experienced with the horse; “I think between the client and horse its less threatening to the client its sort of on their terms” and “its less threatening for them and I think clearly they have more control over it.” Some clients can take this experience beyond the

arena. A clinician notes “so for her to be able to have a safe yet intimate relationship with somebody, something that is much bigger than she is yet she controls and sets boundaries and limits, that is a very satisfying experience and really helps her to, she can generalize those skills to her daily living.” The ability to experience touch under the control of the client leads to touch being safe, which can then allow the touch to be nurturing or connecting.

Secondary Findings

Secondary findings comprised about two thirds of the data by volume. The same method of finding major and minor themes was applied to the secondary findings. Fourteen major and three minor themes were found through an open coding of the interviews. Each theme will be explored in more detail below. The major themes are as follows:

- 1) EFP has all the benefits of an experiential therapy
- 2) Characteristics of the horse as a large, social, prey animal are crucial to EFP
- 3) Clients form a relationship with the horse
- 4) Clients project onto the horse and thus have empathy for the animal
- 5) Boundaries/Limits are established with the horse
- 6) Clients have improved self-esteem from mastery of new skills
- 7) Traditional therapy failed
- 8) Clients self-select and are thus more motivated for therapy
- 9) EFP is a more advanced form of therapy
- 10) Horses are often used as a metaphor
- 11) Horses and humans are often drawn to one another
- 12) Therapists own feelings about their work
- 13) Horses act as mirrors to clients

14) EFP provides a focus off of clients and their diagnoses

The minor secondary themes are as follows:

- 1) There is a spiritual/mindful component to EFP
- 2) Access
- 3) Horses are an extension of play therapy

Major Secondary Themes

#1 EFP has all the benefits of an experiential therapy: 32 references, 11 clinicians

Clinicians in the ring could set up challenges where a client would be frustrated or frightened, but within a window of tolerance. Then these challenges and feelings could be worked through with the help of the therapist. Therapists could also use the experiential nature of the work to locate patterns a client could not or would not bring up in the office. A clinician states “so the idea is to make, to take the therapeutic issues that these kids come with and make them concrete and make them dynamic so they’re forced to work through them” and “its about taking what you’re seeing in the riding ring and seeing where else the same behavior happens.” The addition of the horse allows a client to “see their behavior outside of themselves” and experience real-time consequences. A clinician recalls teaching a couple to ride a series of exercises together, which was difficult for them until she mentioned

You know its ok to talk to your partner, and they did and then it just worked, and afterwards Dad came running, just running up to me saying ‘I know what our problem is! I know what it is we don’t communicate!’ Now this couple had been in family therapy for five years, do you think they had never been told they had a communication problem, but he got it because he experienced it and experienced what happens when you do communicate.

It also gives clients a chance to practice relational skills they have discussed. One interviewee states “say I’ve got a woman who’s having marital problems, I want her to have a horse who’s a little pushy to help her set some boundaries with a husband who is aggressive or inappropriate with her.” The clinician can try to provoke an emotion, coach a client through it, and “the opportunity to really reframe those issues takes place right there.”

The client’s body is also actively involved in the process, which opens different paths to healing; “it it’s a client who is not cognitively able or psychiatrically ready to process at the verbal level they don’t have to so that’s a big benefit” and “I think its partly cuz it’s a visual or it’s a kinesthetic experience for them, so they almost like they’re experiencing it in a deeper way than if you’re just talking about things.” One clinician describes working with a group of women who had experienced domestic violence “so if I can, if we can have them figure out how their body experiences anxiety as they’re getting close to their point where its no longer manageable then when their body starts to go there they know to pull back.”

Clinicians saw this level of involvement as appealing to the strengths of different kinds of learners; “kids who need dynamic, concrete, interactive techniques respond well to this” and “some learning types its important to have something physical to kind of play with, something tactile, visual, something you can see and move around and touch.” The variability of input and potential structure for EFP gives clinicians more room to tailor sessions to a clients strength and learning style.

#2 The characteristics of the horse as a large, prey animals are crucial to EFP: 27 references, 7 clinicians

There were 19 references mentioning the size of the horse. This size can command fear and respect, and bring up issues around safety and trust. Clinicians noted that for trauma survivors who were physically controlled by someone bigger than them “to be able to have a safe yet intimate relationship with somebody, something, that is much bigger than she is yet she controls and sets boundaries and limits, that can be a very satisfying experience.” A horse's reaction to a client can also be a valuable source of input in a session; “and the thing is they give that feedback and because they’re so big it’s harder to miss the feedback and it’s harder to ignore the feedback.” Facing the size of the horse can bring up vulnerabilities for a client “you’re standing up, you’re exposed to a horse, this is a big horse, you’ve got all of the elements all around you, its unfamiliar territory, so you know there could be a lot more vulnerability for a client, so they need to be ready for it.” Facing these feelings and acquiring skills of grooming and riding the horse can then lead to feelings of accomplishment and pride; “and you know some of these horses are thousand pound animals, and for a child to be effectively moving around something that is so large is a huge accomplishment and I think that makes them feel good themselves which can increase motivation even more.”

The fact that the horse is a prey animal is also important to EFP; “as prey animals they spend a lot of their energy trying to figure out if they need to flee, so they’re always kinda evaluating, scanning, picking up on these cues.” Due to this characteristic, “they’re so good at reflecting back to us the signals that we’re sending them.”

#3 Clients form a relationship with the horse: 61 references, 13 clinicians

This theme was one of two in which 100% of the clinicians responded, and received the most references. Relationship with the horse allowed clients to give and receive love and care, as one client stated “I know this horse” and to feel a connection with something. Therapists, particularly child therapists, note that the clients want the horse to like them, will wonder how the horse’s week went, and will bring presents for the horse. One clinician states “but I feel the kids feel like there’s a partnership, and that they want to be accepted by the ponies. I don’t know if they want to be accepted, I guess, I don’t know, that’s a good research question! I’ll have to think about that, I think it has to do with the non-judgmental nature, the child and the pony are a team.” One child was afraid of horses but wanted to ride, so she requested that her picture be posted in the barn so that the horses would know her when she did find the courage to come to the barn. Clinicians often focused on reciprocity, knowing what the horse is comfortable with and what the client is comfortable with and insisting both be honored in interactions. One clinician describes the moment a horse reaches its nose out to a client:

The phenomenal depth of emotional feel that happens when a big beautiful animal with all this muscle and bone and texture and size and resonance reaches out to touch you, that’s incalculable, and that’s where this work happens, at that level of simplicity...so people have to give up their stories ‘I’m just a little stupid kid that nobody loves’ in the presence of this big sleek gorgeous horse that reaches out and snuffles us in something that feels like love, you know, what do you do? So you get emotionally moved...you get wave form to wave form you get touched emotionally you can’t see it you can only feel it. So we’re actually developing in a therapeutic context the fingers beyond the fingers

the emotional touch the hands of feeling you know. A horse can reach out and touch someone.

Clinicians often noted that though clients might be wary of them, they would form attachments more quickly, easily, and strongly to the horse. Once this bond was established, the client felt a connection to place and a higher tolerance for the therapist and the therapy. A clinician states “I feel the work can still be done, as long as they have a relationship with one of the animals we’re working with, I’m just posing questions and allowing them to process through things.” Some clients felt that their horse understood them, and did not want to disappoint the horse. Clinicians stated often that they felt the client loved the horse, and perceived that the horse loved them. One client states “I think Bud [horse] and my’s relationship with this client has been really important for her to figure out that she was a valuable person.” Some clinicians noted that a horse could be seen under the auspices of play therapy. When asked what a horse could offer that a dollhouse could not, one clinician responded “three things, one a relationship, two a relationship, and three....a relationship.”

#4 Clients project onto the horse and thus have empathy for the animal: 19 references, 7 clinicians

A clinician noticed that a number of her clients get “drawn to the horses they see as needy...and um, so then that is interesting kind of grist for the mill you know who are you saving and why and is this really your job.” Clients will often assign feelings and motivations to horses, and often the clinician will directly prompt them to do so to bring clinical material into the conversation. Clients can then become invested in these relationships. One clinician states with certain clients she will underscore how the horse is feeling and focus on how you can know that. She does this because “I think part of our human development is to kind of at some point

realize that there are other people out there and they have values and they have thoughts that are completely separate from ourselves, and these kids have never slowed down enough to pick up on that.” One clinician notes that she deliberately models this in her own treatment of the horses; “we try to teach real respect for the animals, and I think that is a metaphor for treating others better, and again that’s something you wouldn’t necessarily have in a traditional one on one therapy session, but because we insist that they respect certain boundaries and they realize that the animal has feelings and stuff like that, it teaches them to relate to all living beings better.” Some clinicians will pick a horse they think a certain client will identify with to further the process of projection. One clinician notes “so basically what I do is I try to find a horse I think the kid will be able to identify with and use it projecting their own things onto it as easily as possible because you know that’s...for the vast majority of the group they’re barely talking about their own issues they’re almost always talking about the horse ‘oh my pony does this or my pony likes that’ and you know even if its not true you know they could make up an entire story they really believe is the history of their pony.” One clinician notes this is “a nice way to see where the client is coming from.”

#5 Boundaries/Limits are established with the horse: 18 references, 8 clinicians

Handling horses safely requires setting limits for physical safety. Each participant in the equine-human pair will often show their style of limit setting and their experience of boundaries as they non-verbally negotiate for space with each other. A skilled clinician when observing this process can both gain information about their client and intervene to offer insight or suggestion. One clinician notes “the horses also have their other touch which is actually very educational for people who have great difficulties of their own with boundaries, and the horse will very clearly move away from, or snap, or show some kind of discontent, with the client if they are rough or

not appropriate for them.” This ties into the size of the horse, as few clients would be able to disrespect a boundary set by an animal weighing 1,000 pounds. The horse is also able to engage in behaviors to set boundaries, such as biting or moving away abruptly, that would be clearly inappropriate in a human dyad. One clinician states “that’s how we establish boundaries its not cognitive its animal its limbic brain and there’s a great deal of very effective/affective learning that can go on relative to boundaries with animals, particularly with horses.” Some clinicians use touch and the horse as a way to establish boundaries as well. One states “and a lot of people I work with need boundaries, so touching or non-touching or appropriate touching is a real good way to teach them boundaries, and it’s a good way to use the horse because there’s places a horse doesn’t want to be touched either so you teach them to respect the, you don’t just touch them there because you feel like, you have to think about how the horse feels about it, too.” The process of setting boundaries and limits with horses is often very physical and experiential, a dynamic which works in a human-animal dyad and can open a new way to work with boundaries and limits for a clinician. Boundaries can be too diffuse or too rigid, and both can be worked with in this setting. One clinician states “in the case of this selectively mute child, I think touching [the horse] was her first way to communicate with the horse, and then, she started using her voice, but it was a, it broke down a barrier for her in a good way, where sometimes people need barriers to be put up.” If the horse sets boundaries with a client, a client can learn empathy and respect. If the client sets boundaries with the horse, they can learn confidence, have control, and possibly a corrective experience. Depending upon the need of the client, a clinician can choose a horse or arrange an experience to bring any of these threads into the clinical experience.

#6 Clients have improved self-esteem from mastery of new skills: 29 references, 8 clinicians

Many clinicians noted that the novelty and challenge of handling horses presented opportunities for client's to improve self-esteem and a sense of mastery as they acquired new competence; "I think that developing a skill or knowledge or interest in something new builds their self-esteem, and I think that energy makes someone more capable or motivated to make positive changes." Clients can also have feelings of overcoming or achievement; "they say 'wow he's really big' or 'I can't ride him he's too big' and then they end up doing and accomplishing these things, and there's a real sense of pride within them for kind of accomplishing that." These skills can carry over to other therapeutic areas as well. One clinician who ran groups for pre-teen girls with anxiety asked their individual or family therapists if they saw any changes in the girls. She noted "and when I ask their therapists how they've been generally they say they've been much more assertive or they've been speaking up in family sessions whereas before they'd just kind of sit there." Clinicians also noted clients mastering fears and anxieties within themselves so that they would be able to spend time with their horse. Child therapists observed that this pride could translate into a child's relationship with their parents; "the child's self-esteem really blossoms and the parents [seeing their child ride] are like 'that's my kid' and 'oh my oh honey!' and then you know they take photos and they talk about it...it sum...for a child who's coming here with problems it's a great reconnect with the parents." This energy and motivation can be easily folded into the therapeutic milieu in the service of treatment goals.

#7 Traditional therapy failed: 15 references, 8 clinicians

Clinicians noted that a common trend in their client base consisted of individuals who had tried traditional forms of therapy and had not achieved the results they were seeking. They note “they feel they have worked on the issues in traditional therapy and it just didn’t quite get there” and “other mental health practitioners refer kids who just aren’t thriving in traditional therapy.” Some therapists thought this was due to higher motivation and thus compliance; “and it also makes the kids want to come, I mean compliance is much higher than in traditional therapy.” Clinicians note some success with this individuals who have not thrived in traditional therapy; “I get a lot of people who have been through talk therapy that has not worked for them, for whatever reason, and so they’re trying something different, sometimes it works and sometimes it doesn’t” and “there’s the group of people who talk therapy hasn’t worker for, they seem, more of them tend to do well with this.” One clinician who runs groups asks her colleagues specifically for “referrals for kids who aren’t making progress in either traditional play therapy or just whatever therapy the person does” and makes her group completely of these children.

Other clinicians noted that horses could push people beyond their experience of healing in traditional therapy. One clinician notes “and if we [client and I] come across some kind of real tough, something they’re really stuck on that’s usually a sign, lets go with the horses and see what happens.” This was noted in situations where a clinician had horses on property, and so could be included or not as the situation indicated. Sometimes, when the situation was difficult that was the indication to include the animal; “I’ve only done it a couple of times [family session including a horse] and both times it was because the families were really stuck, they weren’t

getting it” and “a lot of the parents I was working with at the time had problems that were entrenched, so it gave us a new look at an old problem that really helped them be able to see their problem in a new light.”

#8 Clients self-select and are thus more motivated for therapy: 16 references, 8 clinicians

Most clinicians noted that people were often motivated to come because of the presence of horses, noting “it’s fun to be with them [horses]” but could not say exactly why people were drawn to the horses; “I think the kids that want to be around the horses want to because they love animals, and I think anybody who loves animals its one of those things that you just do its who you are its what you’re all about, I don’t know that there’s a description that kind of fills it.” Some clinicians had private practices where clients could choose to work with the horses or do traditional office work, some ran groups where all people worked with horses, and others had practices where almost all referrals were aware of the horse-piece and sought them out specifically because of it. However, all agreed that if a client was not interested or did not want to work with the horse, they were rarely pressured to do so. One clinician notes how this motivation can be used in the service of challenging OCD behaviors; “she was so concerned about germs and stuff she wouldn’t touch doorknobs and so, to get her to touch a dirty horse that was quite a thing for her to master but she did and she progressed tremendously because she wanted to ride so badly that she had to push through...and again how long would it have taken to get her past dirt and germs on the office?” Compliance can also lead to good behavior; “I’ve never had to stop a session because a child misbehaved, because they usually you know are motivated to comply.” This motivation is in some clinicians mind at least in part responsible for some of the success of EFP; “so interest in horses is a big piece of what makes a client do well

with EFP I think” and “I think people what are interested in horses, animals, I think that’s a big help, they don’t have to know much about them but they have to be interested in them I think, they have to feel like they want to know more for that intervention to be valuable.”

#9 EFP is a more advanced form of therapy: 51 references, 12 clinicians

The idea that EFP is an advanced therapy was divided into four subsets; EFP requires more skills, it is riskier, it takes clients further faster, and there is more going on at once than in traditional therapy. The skills clinicians referenced were horse skills, clinical skills, and the knowledge base to bring these two disciplines together. The other idea that came soundly out of this section was that this work was not for beginners. A clinician notes “I don’t think EFP is something new clinicians should be doing” and “you need to be an experienced clinician you cannot come right out of school and expect to be able to do this work” as well as “get good clinical skills first, otherwise nobody’s gonna refer to you or you’ll have a lawsuit on your hands in a short time” and “I think you have to clinically know what you’re doing and there’s really not a lot of people doing this work well as far as I’m concerned, frankly.”

When clinicians referenced risk, it often referred to physical injury. If a clinician did not screen a client or equine appropriately, the resulting match could be dangerous. One clinician notes “its much more stressful for me than I ever thought it would be because of the danger of it, I think the kids are a little oblivious most of the time to how powerful the horses can be.” If or when a situation became unsafe, it could do so quickly, so a clinician must always remain alert; “I need to believe the potential [for danger] is always there, in order for me to maintain the kind of vigilance I feel I need to maintain.” Risk could also come from the physical nature of EFP, or from riding and touching the horse. One clinician notes

The whole sort of hypothalamus adrenal pituitary axis is not always functioning well in people who have been neglected, abused, had other kinds of interrupted development, so the kinds of neural circuitry that processes touch, it doesn't function the same and they're not as intact in some of these populations we work with, so I think a big mistake would be to assume that it [touch] feels to them the way it feels to us, that it feels as good to them as it does to us, so it has to be carefully undertaken, carefully monitored; watch for verbal and nonverbal feedback, because the client won't always be aware.

Physical contact can also be a one to one trigger for some clients who are working to resolve a trauma. A clinician observes "we had one young lady who had been gang raped by three neighbors who were brothers, she was pretty far out from that incident and she had been in office based services, was still in office based services, yet she still was triggered by skin to skin with a sweaty, hot, heaving horse; the smell, the feeling, reminded her way too much of her abuse, so there's a lot of warning signs that a clinician would need to keep in mind because its very intimate." Clinicians often saw mounted work as a potential trigger and opportunity that had to be monitored closely based upon the progress of the client. One clinician notes "yeah, I probably wouldn't move to mounted work for a while because obviously the movement of the horse would trigger issues, particularly if you're focusing on that [past abuse] and you never want a child cracked open before they can handle what may come of that."

Clinicians stressed that the addition of a horse into the therapeutic context would move clients further on the arc of their goals, and get them there faster. Part of this was the speed with which problem behaviors surfaced while clients tried to navigate riding; "and in an office, it would take me months to see what I can see with the kid sitting on a horse in a few sessions...in an office we might be talking about it but we might not get that, but because he's sitting on a

horse it was pretty clear.” Clients would also accept feedback from the horse that they might not accept from the therapist. One clinician recalls

I had a man once who just kind of exuded anger, and it would take many sessions of psychotherapy to get to the point where it would show him that people avoid him because he exudes anger, but I took him out to watch the horses and usually they would come up to the fence, but they all started coming to the fence and they got about 6 feet from it and they just stopped, so I asked him why he thought that was and he said ‘maybe they’re not friendly’ and I said ‘yeah could be, what else’ and he went through a whole bunch of reasons and then he finally said ‘well maybe they don’t like me’ and so I said ‘hmm...why would that be?’ so again went through a bunch of reasons and so finally he came around to ‘maybe they’re afraid of me’ and I thought about it afterwards and I thought that would have taken 3 months in an office to get to that point, and he saw it in just one session, just by how the horses reacted.

Clinicians also noted the level of input and stimulus was much higher when conducting EFP than in an office setting. One clinician notes “if you’re a therapist and you’re looking at an interactive situation you have to be really aware with both heart, mind and experience and be going always back and forth, adjudicating and adjusting the situation.” Another states “and I find as a practitioner, the level of listening is very different outside in nature, because I’m watching the horse while having a conversation with the client to see what the horse is doing, and I’ll invite the client to watch the horse as well but its not only that group that I’m paying attention to it is the environment and being a working barn a kid may interrupt you or any number of things could happen so it requires a different level of listening than sitting in an office one on one.” Though this takes more energy from the therapist, it has potential benefit for the

client. One practitioner states “it takes more effort for me to stay present, there’s more to pay attention to and sort of filter through; there’s more things to kind of pick from to introduce to the session but it gives the client more opportunity to say yes or no ‘no no its not that but it is this.’”

In some programs in addition to the therapist, client, and horse sometimes a fourth player is added in the form of a volunteer or equine specialist who’s job is to handle the horse safely and collaborate with the therapist in the handling of the animal. One clinician notes what this can bring to a session

because not only are you paying attention to what you’re bringing to the session and how the horse is responding and what he’s bringing but you also have the equine specialist if you’re doing mounted work and every piece is involved in that. You have no clue, I mean lets say you’re doing work and you have an equine specialist who happens to be a male and you’ve got a female patient , a young adolescent girl who may have a crush on this guy, the touching of the horse could have a whole other meaning you’re not even privy to or whatever, you know what I mean so you have to really understand what the animal piece is bringing into the session...a lot of people come to this work and just think ‘oh its easier’ or ‘you don’t have to pay attention to all this stuff’ it drives me insane.

In sum, clinicians experienced a kind of cycle in which the high level of input both opened up more opportunities for the client as well as more risk, and this in turn forced them to be more alert and more skilled as clinicians to make sure the risk was neutralized and opportunity realized. If the opportunity was taken, clients could experience faster and more potent therapeutic progress than they might have achieved in a conventional environment. Yet again, this progress had to be closely monitored to make sure it was not too overwhelming for the client. All this was involved in their cautions that this work was advanced, and not for

beginners. One clinician states “it isn’t just the horse, it is the horse and the therapist, it is the synthesis that’s what’s key it’s the synthesis. You know there’s no magic cure in the horse although we’ve all had our magic moments, it is psychotherapy and it is a therapist with an equine.”

#10 Horses are often used as a metaphor: 34 references, 10 clinicians

Clinicians sight the use of metaphor as a particularly useful and critical piece of EFP. The horse in particular can be used as a metaphor for any person in the client’s life, for a feeling, a problem they might be facing, a relationship, the therapist, or themselves. One clinician notes “I talk about the horse as the co-therapist and there being an opportunity to build a relationship with the horse and for them to build a relationship with the horse that then the client and I can talk about and compare to other relationship they have. There is potential for them to learn a lot from the horse about all their relationships by developing a relationship with the horse.” Another clinician notes “everything you need to do to be successful in a relationship with a human you can do with a horse, only horses are a whole lot nicer to you.” One clinician recalls working with a young girl who was having problems getting along with her mother. She states “well sometimes the horse is cranky and sometimes your mom is cranky and sometimes you’re cranky, and when you’re cranky how long does it take for your horse to get cranky and how can we prevent that you know? The horse-human relationship becomes a model for the human-human relationship.”

Horses can also be metaphors for the client, something about the client, or for whole groups of people. One clinician states

Lots of these women are ‘oh I loved horses as a kid and lost contact with them’ or ‘they’re beautiful they’re majestic they’re graceful they’re powerful they smell good they’re soft’they have a depth and a sweetness and a beauty to them that I think as women we’re attracted to that. I think they show us ourselves in a way that we lose touch with, which is why being around horses as little girls is so important. We don’t have a lot of role models for power and beauty and majesty as women and girls and a horse represents all that and can bring that out in us.

Another clinician notes “I recently rescued a small pony and brought him to work. And at first you know he was extremely skittish, I’m sure of humans, and it was a great metaphor for a lot of the kids who had trauma, who came from different adoptive homes, that kind of thing, I would work with the kids on helping him calm down ‘what are some coping skills the pony can use’ and then I’ll use it as a metaphor for them ‘what are some of the coping skills you can use if you start to get nervous.’” The use of metaphor can help a client move skills or observations from the equine to themselves, from the session to their lives.

The horse can also be viewed to represent the therapist. One clinician states “Well I think the horse is an extension or a metaphor for the therapist often. And I think you have to be extremely careful about what and how that child or adult is interpreting that,” especially in terms of touch or physical contact. Another therapist states “the equine, at that point, really becomes a conduit, and can tap into so many issues that have to do with touch, and I think it’s a really valuable part of the experience.” A third clinician stated “often the first contact I have with my clients is that my dog is out there [in the hall].” Contact with the animal can in many ways mean contact with the therapist.

#11 Horses and humans are often drawn to one another: 13 references, 8 clinicians

Clinicians reported seeing either a horse that quickly approached a client, or a client that was drawn to a particular equine, sometimes for reasons that they could not explain. Though there are some theories as to why these pairings occur, there does not seem to be an ultimate explanation. Some clients are drawn to particular activities with the horse as well. One clinician states “I’m frequently surprised by who they’re drawn to” and “yeah that little boy with the anxiety really surprised me, I thought he’d be all gung-ho wanting to ride” and “the person I thought would never want to ride does and does well with it or somebody I thought would be good at it, it doesn’t grab them.” Another clinician noted “there’s always certain kids in the group who I anticipate are just gonna wanna ride the whole time and then I’m usually wrong to be honest.”

The fact that a client is drawn to a certain horse can sometimes be clinical information. One clinician states “folks who have been sort of battered for the most part do one of two things; they’ll either pick the safest horse in the barn or the most aggressive horse in the barn” and “so that was an absolutely fruitful discussion for her and she could see how she had just repeated her pattern with men right there in the barn and how elucidating that was for her.” Another clinician notes “I do have clients who to a certain extent can exert choice over who they work with that day, and you know a lot of that taps into their own issues and challenges that they’re aware of.” A child clinician notes “often times they’ll choose the horse that has the same issue as them which is kind of interesting” and “I’ve noticed over the years that the kids who have behavior problems themselves really gravitate towards him.” One clinician will leave room in her program so that if a client is really drawn to a horse they can establish that pair; “so we’ll say ‘so and so we’re gonna put you with him’ but ‘oh no I really want to work with that horse’ well ok

we'll switch the schedule around because if a person is feeling really drawn to the horse then we'll honor that because there's something going on there." That 'something' could be a projection, it could be an established behavior pattern, it could be a feeling of allying with a horse they perceive as similar to themselves. In any case, it is important that a clinician notes this draw and brings it into the session.

#12 Therapists own feelings about their work: 9 references, 8 clinicians

The majority of therapists noted that horses had impacted their own life positively. They state "I mean, I know what my riding lessons as a kid did for me as an adult" and "its been really good for me personally" and "they're just a part of my energy system and boy when I'm down and I'm with them my energy comes back" as well as "I know personally that it was very therapeutic for me as I went through some hard things." The presence of the horse affects the state of the clinician as well. A therapist states "how does it affect us to be in the situation and have the animals there because we're both you know such animal people so there's definitely some bias there, I think that we're happier and more comfortable and so I think that may play into it." Still another clinician observes "I think I accomplish more with the horses mostly cuz I know more about it, I think I just, I know more about the horses and I'm more comfortable with that so I tend to do that more." A child clinician states "I'm fortunate in that I really love what I do and I have the ability to work with animals and to work with kids at the same time." The ability of the therapist to be in an environment where they may have had positive past experiences, doing an activity they enjoy, makes for a more comfortable and available therapist as reported by some. In regards to horses one clinician states "they're treasures, some of my highest moments in life have been in horses."

#13 Horses act as mirrors to clients: 46 references, 13 clinicians

This theme marks the second that received comment from 100% of the sample. The basic theme here was that the horse can accurately perceive humans emotion and will react uniquely to it. It is the clinician's responsibility to be able to assess the equine reaction and dialogue with the client about it. For example, some horses can tolerate a client with high anxiety while others will match it by displaying their own anxiety through their body and behavior, thus a client can see their fear acted out by a one thousand pound animal. How and if a clinician might choose to enact this scenario by choosing a horse they know has that reaction will depend much on the client and their progress. Another theme that emerged is that the horse is never wrong about this, "the horses are absolutely perfect barometers" and in fact might be more astute than the clinician "making sure there's not something the horse is picking up on in the client that I'm not even aware of." One clinician states "basically the body doesn't lie, and horses inhabit their bodies much more than human, they are embodied more consistently than humans, they don't get lost in their heads, and so typically you know they're much more reliable than people as far as the congruence, the feedback, and the connections between emotions and behavior." One clinician recounts an incident in which

I had a young guy who, well they weren't sure whether or not he had abused animals but there was a strong question of it, and when we were going around doing the diagnostic assessment, he was you know a sort of very friendly happy kind of guy but you could feel something underneath. And he went to pet one of our mares and she just backed into the back of the stall and I thought 'well there's your answer right there. Somebody may be a superficially very well-controlled person but is carrying a lot of anxiety or anger with them and when they step into the stall, the horse might pick that up, you know just kind

of in my human observation but the horse has such a strong 6th sense they might feel this agitation coming into the stall and back away from the client and that's information for me.

A third major component of this theme is congruence, defined as when an inner state matches an outer presentation. Horses were said to be incapable of being incongruent, and when they sense incongruence in another being they become agitated. Some theorists believe this is in part because incongruence is a mark of a predatory animal. Thus, a skilled EFP clinician could get clues to a client's inner state by knowing how the horse usually reacts in certain situations. One clinician states "and it's the horses often give me information by how they react to the person that helps me decide what to do next in a therapy session." One clinician relates a situation in which she sent a child who was upset from a bad day at school into a stall to catch a horse, but the horse would not allow the child to get near him, which upset him further. The clinician suggested that the child tell the horse what he was feeling and why "as soon as the kid said out loud what he was feeling and why he was feeling it there was a tremendous load off the kids shoulders by owning that and putting that out there on the table then the horse responded positively to him and approached him and it was just a wonderful experience for the kid." The ability of a horse to read its environment, especially the intentions of predatory animals near it, is crucial to the survival of the species. It is also a lynchpin of EFP, and in the hands of a skilled clinician can be used for a client's benefit.

#14 EFP provides a focus off of clients and their diagnoses: 22 references, 8 clinicians

The presence of a third or even forth being in a session allows the focus to be off the client or 'identified patient' for at least some of the time. One clinician notes that having an

activity to mutually engage in can bring fluidity to a conversation. She states “and again the focus is being taken off of themselves so it’s a great way you’re not just staring at someone like this (bugs eyes out at interviewer) but you can just talk about what happened at school and what’s going on in their life” and “the child doesn’t have to think about anything you know we’re just walking around and they can go on and on about whatever issue we’re talking about.”

Another clinician notes “it’s those nice, quiet moments when they’re concentrating on something else” that often lead to an advancement in therapy. A clinician recounts that a client would not engage with her when talking about her problematic relationship with her mother “I’m gonna run into several problems, boredom, resistance, all kinds of things” but “if I frame it in terms of working with the horse she gets it, she can hear it, so it really gives me a back door entry into the issues.” Some clinicians noted that engaging with clients in a mutually enjoyable activity allowed a bond to form more quickly, which then brought them to an alliance that allowed difficult material. A child therapist noted that having horses made them “cool” which then meant “it makes them like us more hence they’re going to be more open to talking with us;” she adds “we don’t always come across as therapists, more as someone that they just come and talk with and associate with positive things.” By building skills clients “feel like they’re much more than their diagnosis” as they are riders and a part of the stable. The barn can be viewed as less stigmatizing than the office “and why shouldn’t therapy be fun?” Some clinicians reported that their clients “hated therapy, period, hated therapy, so we could pretend it wasn’t therapy, essentially, and still achieve a therapeutic result.”

Minor Secondary Themes

#1 There is a spiritual/mindful component to EFP: 7 references, 4 clinicians

When clinicians began to explain the results they would see in EFP, they used phrases such as “and there’s no time to sit around worrying about it, it’s very much in the moment” and “almost like a meditation.” One clinician noted that mindfulness work was “a part of the texture” of EFP “and goes right along with that.” Two practitioners in particular noted themes of spiritual evolution and a need to learn how to co-exist more peacefully in an inter-related ecosystem. The emergence of EFP was seen as a step in that direction. One clinician states “sections of humans are evolving spiritually and we’re seeing the intersection and the gifts of the whales, and dolphins, and horses, so being aware of that I think is one of the underpinnings of why this work is becoming more and more popular.” She goes on to state “I think we’re really at a pivotal point in terms of how we’ve affected the environment and culturally, our economic system, I think its all pushing us forward because we see the need to teach people how to facilitate change.” To partner with horses is then in this sense an example of a larger partnering that some see as a necessary change if we are to create a sustainable future.

#2 Access: 6 clinicians, 12 references

EFP is financially expensive to start and maintain. This reality shapes who can practice and who has access on a physical level. One clinician who has both a private home-based practice as well as affiliation with an agency notes that the clients who receive the EFP services on the whole seem to be mentally healthier; “probably at least to some extent they have more financial resources, so which came first they had more financial resources so they had more access to better treatment or they had better outcomes because they had fewer financial problems or they don’t have to depend on insurance the same way someone else might have to...”

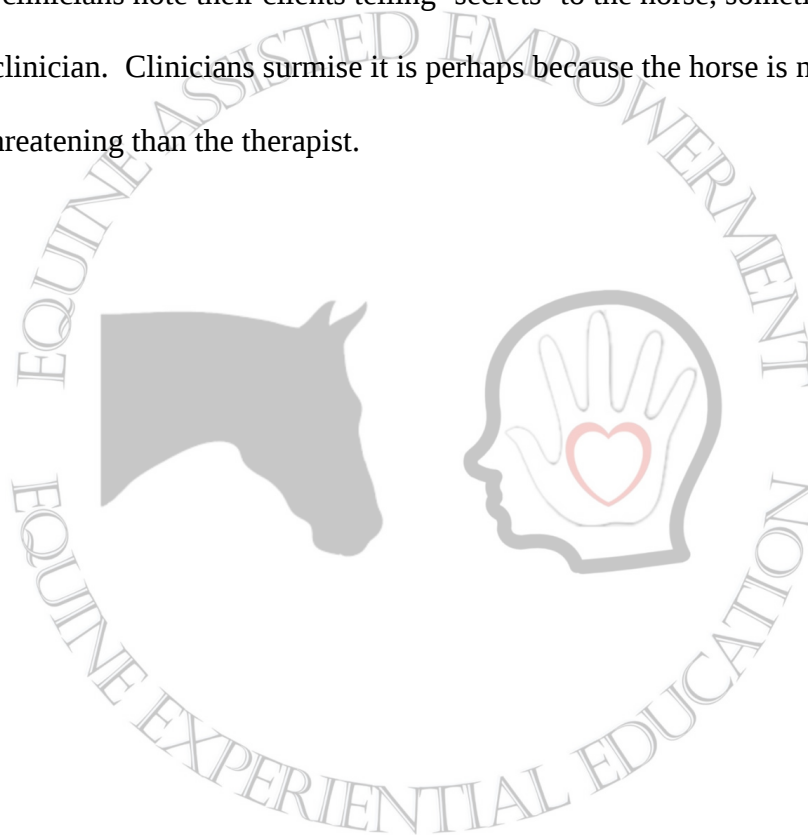
Another clinician noted “we’re metropolitan and we’re not a non-profit so we see a lot of very wealthy clients.”

This translates sometimes to a feeling of exclusivity within a session as well. The animals can be seen as “so beautiful, so large, and that seems particularly inaccessible particularly for kids who don’t have animals in their lives.” A client’s experience of becoming a skilled equestrian “becomes like this alternative identity for a lot of them” and “feeling a sense of their identity, like they have something special that they’re good at that none of their friends are doing, and I think its really nice to take them out of their environment and give them something like this.” Another clinician observers “you know its almost like there’s a club, a special place, they’re getting the inside scoop, and I think the kids are excited to get that information” and “I don’t want to say the word privileged, but its like they’re seeing the inner workings of what’s going on, they feel like its special information.” This exclusive access, both on a systemic level and the level of an individual psyche, is noted by clinicians who then use it in the service of self-esteem and growth. Clinicians often noted their frustration at systemic, financial barriers that limited their ability to push forward with what they consider a potent, successful therapy and simultaneously limited potentially interested clients in reaching them.

#3 Horses are an extension of play therapy: 11 references, 6 clinicians

Four of the thirteen practitioners sampled stated directly that they saw EFP as play therapy; “it [the horse] is another tool, you know a tool that is furry and fun and they can give a lot of feedback you know they have a lot of emotions” and “if it goes anywhere I guess it would be under the same sort of genre as play therapy, the horse just happens to be a modality in the way that a dollhouse can be in a certain way or a chair in a room.” Six clinicians employed a technique in which they asked the client to talk to the horse rather than to them, in the way

clients are sometimes asked to talk to an empty chair that represents someone in their life, and reported success. One clinician relates a story in which she saw a client who had been accepted to college but was struggling with his last semester of high school; “he went on the go to college and graduate high school, so that six week intervention where I didn’t even talk to the kid I just gave him some exercises to do with the horse, and told him to go talk to the horse, and it worked.” Child clinicians note their clients telling ‘secrets’ to the horse, sometimes in the presence of the clinician. Clinicians surmise it is perhaps because the horse is not ‘shocked’ or is viewed as less threatening than the therapist.



Chapter V

Discussion

Primary Findings

The primary findings were themes that centered directly on the subject of contact between horse and client in a therapeutic setting. The secondary findings were those that centered on equine facilitated therapy as a subject but did not reference touch. Below, themes from both the primary and secondary findings are paired with relevant points in the literature to further tie the findings into the information that has already been gathered in the field. If these pairings suggest other areas for research, that is also noted. The same process is repeated for the major and minor themes in both the primary and secondary findings. Finally, the importance of this study to the field of clinical social work and its implications are explored in the final paragraph.

Major Themes

Using touch with clients who have experienced a body-based trauma is highly debated in the professional literature. However, when surveyed, abuse survivors who experienced touch respectfully and appropriately during a therapy session reported therapeutic benefits. These benefits included trust, self-esteem, an opportunity to set limits, and an experience of touch that was not violent or sexual (Bonitz, 2008). Within an EHT context, sexual danger is removed, and touch is relegated almost entirely by the client. Clinicians surveyed noted that the attention given to the bodily experience of the client, as observed in major finding # 1, and the bodily experience of the horse seemed especially healing to survivors of body-based trauma. If the

same elements necessary to make client-therapist touch therapeutic are present during client-equine touch, clinicians surveyed reported benefits to the client.

A common word clinicians used when describing equine-human touch (EHT) was “safe” as described in major finding #3. When that word was defined, it meant several things, including non-judgmental, accepting, and soothing to the senses. Most frequently, however, it meant nonerotic. Given the statistics regarding sexual abuse of clients by therapists, attention to safe touch between therapist and client is a crucial and responsible matter. Though no direct sexual abuse could come from the horse, contact could be triggering. EHT could also be unsafe in terms of injury. Thus, sexual danger is replaced with physical danger. How does this impact EHT as an intervention? What does it allow for therapeutically? The themes in the findings offer some suggestions to answer that question. Clinicians noted EHT seemed calming, connecting, empowering, grounding, allowing for differentiation, and exploration of touch. These basic explorations, such as discovering what kind of touch is agreeable and noticing how the other participant communicates boundaries, can be safely explored in a horse-human relationship. This is, as one interviewee pointed out, is “kind of counter-intuitive when dealing with 1,000 pounds of animal.” And yet, EHT could give clients a chance to experience positive touch safely, at their own pace. Thus, differentiation of touch, as noted in major finding #2, can be explored from the limbic system in basic to advanced ways.

Research suggests a division between transference based on symbolic language and nonverbal transference coming from the body and from early, preverbal experiences. These early experiences are often accessible only through nonverbal channels. If this is the case, therapists must consider how effective they can be in accessing preverbal or body-based impasses through verbal channels (Toronto, 2002). Some clinicians noted that one benefit of

including horses in the therapy is that part of the therapy can at times be a completely non-verbal exchange. At this point, entrenched defenses could be avoided and the limbic or 'animal' brain was in contact with another animal brain. This relationship was seen as allowing clients to experience deeper and pre-verbal structures and channels while still under the watchful eye of a trained professional. Horton (1995) notes that language can never completely supersede touch, the earlier form of communication. Is it possible that animals can be brought in to participate with clients in this communication? Could this explain the connection clients feel through EHT as described in major finding #7, "EHT as connection?" Is an animal a more appropriate partner, and what is the place of a practitioner in this dialogue? The latter question is energetically debated in the literature, while the former question has received much less attention as a possible solution.

Another major finding involving EHT noted that horses could touch clients, both physically and metaphorically, in ways that the therapist could not, as described in major finding #8. Horses are used as surrogates, extensions, substitutes of the therapist by the therapist to create a place in which a client can have a deep, physical primitive connection to something outside themselves. The therapist can then incorporate this connection in addition to their own connection to the client and their own connection to the equine to further the therapeutic goals of the session. In Harlow's (1958) classic study of young monkeys, his research suggested that mammals prefer touch over food (Durana, 1998). Toronto (2002) noted that trauma that occurs before a child has developed significant psychological structures may be lost to symbolic representation. Later, in a therapeutic situation, this child turned adult may have only a superficial response to verbal interpretation, which requires a certain amount of intellectual understanding. The presence of a safe touching relationship in a therapy session led many

clinicians in this sample to feel that they had an unspoken avenue to tap into issues of touch. Leder (2008) notes that the body may harbor deep-set and preconscious modes of ‘speaking’ through contraction or hyper vigilance, and that language may be an insufficient medium to address these patterns. Many clinicians felt that EHT offered other avenues when verbal insight no longer made the progress hoped for by client and clinician.

Geib (1998) speaks of four recurring themes correlated with patients reporting positive feelings about touch in therapy, as noted in the review of the literature on the topic of touch. One of those themes was that touch was verbally processed after it occurred. The findings report, as evidenced by major finding #11 in the previous chapter, that the majority of clinicians and therapists in the sample engage in dialogue about touch between human and equine, and between therapist and client, as a practical necessity of the work. This conversation often takes place before, during, and after contact. What impact does this have on the client’s experience of touch in a session? And can these measures be applied to human animal touch, or do different variables contribute to the effectiveness of human animal contact? However, it is more reasonable to assume that verbally processing contact between client and therapist would fit more soundly into Gleib’s framework, and thus could help lead to more positive responses from clients.

Minor Themes

Gleib’s second theme centered on the client having a sense of control over the contact between themselves and the horse. This came across as minor theme #1 in the primary findings. Some clinicians felt that the touch between horse and client was on the client’s terms, and that “they [the client] clearly have more control over it [touch].” How client’s experience this control can be hypothesized as a potentially positive or corrective experience. However, without the

direct voice of the client, it is difficult to say for certain. The observations of some clinicians, though, do support that crafting a relationship through a touch that is controlled by the client can have healing effects. This could possibly blend into Geib's fourth point in which touch is perceived positively when it matches the overall level of intimacy established in a relationship. If a client has control over this touch, it could be postulated that it would be regulated to an already established level of intimacy. Though comparing Geib's measurements to the findings of this study are useful and have some interesting overlap, they raise more questions than they answer and suggest that a study including clients' direct experiences of touch in EFP could be quite fruitful.

Secondary Findings

One striking result of the research was that two thirds of the interviews, as measured by volume of typed pages, could not be directly related to EHT. Often, clinicians had not thought about it in terms of the bodily experience of their client, or sometimes not as an intervention and occasionally not at all. Toronto (2002) states "due to its importance as a human need, the strict avoidance of it [touch] is not neutral but rife with meaning. The absence of emphasis on bodily experience, of either patient or therapist, has been so striking as to garner charges of defensiveness." Could this absence of emphasis on the stated subject be influenced by collective cultural aversion to the subject? Sakiyama (2003) notes that Western cultures, rooted in Judeo-Christian traditions, can be viewed as touch deprived and individualistic. Stenzel (2004) notes that therapy in the United States is embedded in the culture that surrounds it and responds to the cultural norms in which it lives. Phelan (2009) notes that some have argued that touch would be a more acceptable intervention in both physical and mental health settings if prevailing attitudes were more permissive. This suggests that the benefits derived from touch are recognized, but

that cultural impositions stand in the way. Could these same cultural impositions be a factor as conversation consistently veered away from touch?

Major Themes

Secondary major theme #5 spoke to the boundaries and limits that horses and clients achieved between each other. These boundaries were achieved often by clear physical feedback on the part of the horse. This feedback could sometimes cross the line into physical danger. This danger was even viewed as some clinicians as a potential positive, giving teeth, sometimes literally, to boundaries set by horses. Clinicians noted that clients could accept the feedback from horses in ways that they might not be able to from another person. Though some research has shown that animals can offer companionship similar to a humans, and thus the ability to exchange a human for an animal is at the root of the therapeutic value of animals (Hallberg, 2008), the findings suggest this is not true in all situations. There are situations where the same feedback from a human would in no way be tolerated or accepted, but that basic messages or processes such as dividing physical space in an arena, might be better orchestrated by the horse rather than the human.

Horton, Clance, and Sterk-Elifson (1995) surveyed 231 clients who were actively involved in psychotherapy at the time of survey. Sixty nine percent indicated that touch fostered trust, openness, and a stronger bond with the therapist. Forty-seven percent indicated that touch increased self-esteem. Touch was also perceived as a factor that allowed them to feel valued, which helped them to feel better about being in therapy. Therapists report that touch may meet a client's need for containment, affection, and parenting, as well as mirroring content and exploring the unconscious (Phelan, 2009). The findings of this survey support several of the secondary findings of this study as well. Secondary finding #6 refers to the increased self-

esteem found through mastery of skills, although self-esteem gained by a horse allowing or choosing to touch a client could also be included under this heading. Secondary finding #13, horses act as mirror to clients, is especially relevant here. In the 1995 survey, therapists reported that touch may meet a client's need for mirroring content and exploring the unconscious. Clinicians in this present study unanimously stated that what they observed in their sessions was the horse acting as a mirror to the client, to reflect the client back to themselves through the behavior of the equine. There was only one other theme that received the attention of 100% of the sample. Thus, the importance of this theme cannot be understated. Although horses were reported to accurately mirror client's inner state with their outer presentation, and in fact this ability on the horse's part is what drove many clinicians to include them in their work in the first place, touch was not always involved in this exchange. In the specific case examples therapists related, this exchange between client and horse often took place across a distance. Thus, though mirroring could be argued to be a critical component of EFP, touch is not necessarily a critical component of mirroring.

Minor Themes

One minor theme, #1 in the secondary findings, was that of a spiritual or mindful theme to EFP. This theme fits into a broader dialogue of eco-psychology and biophilia. Clinicians referenced a connection to nature to the setting of barns and corrals, a connection to other through the horse, a connection to self nurtured through the therapy, and a few took it further to a connection to a spirit or Divine presence. This theme was not as prevalent in the literature, particularly the literature on touch in the therapeutic encounter. Moving back to a cultural critique, this could suggest the lack of differentiation of touch within many Western cultures. The tension between protecting clients from harmful touch, and accessing the potential benefits

of touch, may have tipped so that clients are denied benefit as well as harm. Where to draw the line on touch in a therapeutic encounter is not clear. However, a case could be made that the fact the potential of touch, even into the spiritual realm, is not discussed points to a dearth of possibilities in the professional dialogue and a focus on the harm. It could also point to another avenue that the horse, and touch from and with the horse, could open up for clients in the therapeutic encounter.

Conclusion

Through an examination of the relevant literature as applied to the findings of the study, it would seem to suggest that EHT can be beneficial to clients. What impact does this have on clinical social work? First, the possibility of a treatment that can more directly speak to pre-verbal trauma or touch deprivation in a client warrants investigation. These are issues that may not be as easily addressed in traditional therapeutic settings. Second, touch is a highly debated intervention, which some link to sexual exploitation of clients by therapists. If this intervention can be delivered in a safer method, or a method that is more accessible and less threatening to clients, then that method should be considered. Third, there is increasing research that shows the body as a potent site of healing. Therapies that can include the body can possibly harness this healing potential for the benefit of clients. Fourth, the dialogue surrounding touch within the therapeutic community has historically been polarized into those who believed in the healing power of touch or bodywork and those that followed an abstinence model. The large gray area in between, which more accurately reflected the actual practices of many in the mental health community, was not explored or documented in the literature for some time. Thus, continuing and broadening the dialogue surrounding touch in the therapeutic community contributes to the literature that tries to further understand touch and how it harms and how it heals. Leder (2008)

notes the importance of touch as a sense and in human development has been well documented. Touch as a medium can create a close embodied dialogue. In the end, it might not be something the clinician or the patient does, but something that unfolds in the space between, and supports the space that contains it. If the addition of an animal or horse into ‘the space between’ can further benefit a client than the field should explore that benefit.



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Appendix A

HSR Approval Letter



Smith College
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February 16, 2011

Ann Marie Sexauer

Dear Ann Marie,

Your revised materials have been reviewed and they are fine. We are glad now to give final approval to this very interesting study.

One small, thing, we think you should have some form of address for the email and also include your connection with Smith. Please make it clear that you have an institutional connection as it enhances credibility. Please send a copy of the corrected email to Laurie Wyman (lwyman@smith.edu) so that it will be in your permanent file.

Please note the following requirements:

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

In addition, these requirements may also be applicable:

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

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

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

I know that you did start on another project which you had to give up and it must have been hard to start over but you have developed a very nice study that has real value. After reading your application, I was thinking about how much I enjoy the physical connection, the touch of my two rather large, standard poodles. They sit on the couch with me as close as they can get and it is very therapeutic!

Good luck with your project.

Warm regards,

A handwritten signature in black ink, appearing to read 'Ann Marie Sexauer'.

Ann

Chair, Human Subjects Review Committee

Appendix B
Recruitment Email

To Whom It May Concern:

I am a Master's Level student at the Smith School for Social Work looking for clinicians who include horses in their therapy practice and are willing to conduct a one-time one hour interview. I will travel to you and your information will be confidential. This research will be used specifically to complete my MSW thesis and more generally to advance the available knowledge base in this field. Very little research is conducted in this area and I hope this work will start filling some of the gaps. The specific topic is: equine-human touch as a specific intervention in the therapeutic encounter from the perspective of the clinician.

If you have questions, are interested or know someone who might be please contact me at asexauer@smith.edu, or 617-543-2520. Feel free to forward this email. Thank you.

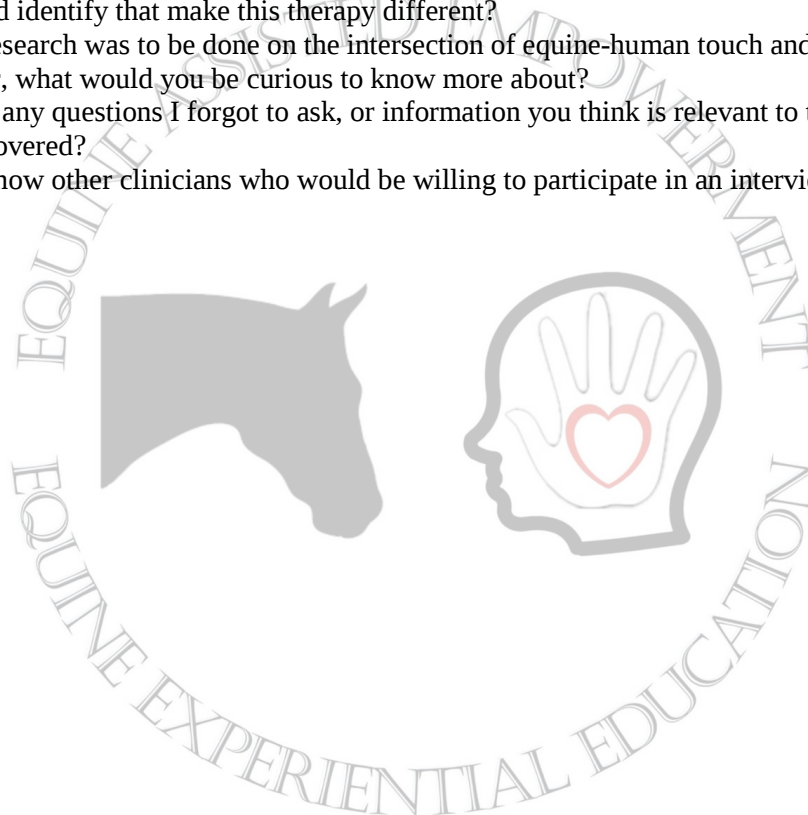
Annie Sexauer

Appendix C

Interview Questionnaire

- 1) What is your age?
- 2) How do you identify your race, gender, nationality?
- 3) Briefly describe your occupation held while working with horses.
- 4) What are your educational/professional qualifications related to this occupation?
- 5) How long have you been in practice?
- 6) Briefly describe your client base.
- 7) What are some of the presenting issues you see?
- 8) How do you use the horses in your practice?
- 9) Do you use only horses or other animals?
- 10) What is a typical duration of treatment for a client working with the horses? In traditional setting?
- 11) Do you practice psychotherapy without animals or horses?
- 12) How is the horse involved in the session?
- 13) Is there a screening/assessment process before a client works with a horse?
- 14) Do you have rules for regulating touch between yourself and your clients?
- 15) If so, do you talk to your clients about these rules?
- 16) What are your touch boundaries with clients? Do you hug clients, shake hands, touch shoulder, back, hand, etc?
- 17) What are your feelings on touch between client and therapist as a therapeutic technique?
- 18) What are your feelings on touch between client and horse as a therapeutic technique?
- 19) Do the touch boundaries between yourself and your client change with the presence of animals?
- 20) What, in your mind, is the difference between touch involving client and therapist and touch involving client and horse? In terms of physical description, theory, potential, what the horse can give vs. human, what it feels like for the client, which clients, etc. How as a clinician would you orchestrate this intervention for the benefit of the client, in which situations, and why? Why wouldn't you?
- 21) What exactly does equine-human touch look like? Can you give examples?
- 22) Do you plan equine-human touch as a specific intervention?
- 23) Do you see a difference in mounted and unmounted interventions, in terms of which client's prefer what, therapeutic response, etc.
- 24) How do you match a particular client with a particular horse?
- 25) Do you work with specific horses for specific situations? Why? Can you give examples?
- 26) What are the clients' reactions to contact with the horse? Can you give examples?
- 27) Do you think there are particular clients or situations that respond particularly well to equine-human touch?
- 28) What is the effect of touch on the horse? Do certain clients/situations have a different impact on the horse?
- 29) If you were to purchase a horse for your work, how would you make that decision?
- 30) Is there a difference between client's who have ridden and those who haven't in terms of therapeutic response? Motivation? Other differences?
- 31) Are gains made in EFP generalizable? Are they steady on follow up?
- 32) I read a quote in my research... "the magic of attachment is touch, and touch takes place through the skin..." do you see this reflected in your clinical experience?
- 33) Do you think there are particular clients or situations that respond poorly to equine human touch? Have neutral or no response?

- 34) Have you, the client, or the horse ever experienced physical danger in relation to equine-human touch?
- 35) This is a growing field with lots of new clinicians entering into it. What common mistakes do you see novice EFP clinicians making as they start out in this field? What do you wish you knew then that you know now?
- 36) What do you think accounts for client's motivation to be with horses?
- 37) Do you think equine-human touch can have harmful effects on any of the participants?
- 38) What accounts for client's motivation to be with horses? Does this differ if they've ridden before? Does this motivation change after they've spent more time with the horse?
- 39) What has been your most striking clinical experience while working with horses?
- 40) How important do you think touch/contact is to EAP? Could it be done without it?
- 41) I've identified touch/physical contact as an aspect that makes EFP unique, are there other aspects you would identify that make this therapy different?
- 42) If more research was to be done on the intersection of equine-human touch and therapeutic encounter, what would you be curious to know more about?
- 43) Are there any questions I forgot to ask, or information you think is relevant to this topic that we haven't covered?
- 44) Do you know other clinicians who would be willing to participate in an interview?



Appendix D

Informed Consent

Dear Participant,

My name is Ann Sexauer and I am a Master's student in the Smith College School of Social Work. I am studying the effects of touch within the therapeutic encounter of Equine Facilitated Psychotherapy (EFP). This research will be used toward my Master's thesis and for possible presentation and publication.

Participants in this study must be clinicians, currently practicing or retired. Part of their clinical encounters must take place within the modality of Equine Facilitated Psychotherapy, and EFP must include physical contact between equine and human client. The participant must be fluent in English. Participation in this study will include one interview, lasting between 30 and 75 minutes, and include questions about touch in the context of EFP, as well as a few demographic questions. I will conduct, audio record, and transcribe the interview.

The risks associated with this study are minimal. The information gathered will be used in part to assess the efficacy of this type of program and thus contribute to our overall knowledge of what can and cannot be expected from touch in the therapeutic encounter. In addition, a chance to critically reflect on the interventions one uses in practice might prove personally beneficial. No additional compensation will be provided for this study.

The identity of participants in this study will be kept confidential. Written materials will be kept in a locked file cabinet at the researcher's home and all electronic data will be password-protected. If quotes or vignettes are used, they will be carefully disguised. My Research Advisor will have access to the data only after all identifying information has been removed. Participants are reminded to please not use names or identifying characteristics of clients when discussing cases. All data will be kept in a secure location for three years as required by Federal guidelines. Should the materials be needed beyond the three year period, they will continue to be kept in a secure location and destroyed when no longer needed.

Participation in this research is voluntary. Participants are free to withdraw any time before April 15th, 2011. Should you choose to withdraw, the data and all materials pertaining to you will be destroyed. If you have any concerns about your rights as a participant or any aspect of this study, please call the Chair of the Smith College School for Social Work Human Subjects Review Committee at 413-585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY. I WILL PROVIDE YOU WITH A COPY OF THIS FORM, PLEASE KEEP IT FOR YOUR RECORDS. THANK YOU FOR YOUR PARTICIPATION IN THIS STUDY.

Name _____ Date _____.

If you have any questions or wish to withdraw, please contact me at 617-543-2520 or asexauer@smith.edu