Equine-Assisted Psychotherapy: A Descriptive Study

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EQUINE-ASSISTED PSYCHOTHERAPY: A DESCRIPTIVE STUDY

by

Erica Jex Gergely

A Dissertation Submitted to the Faculty of The Graduate College in partial fulfillment of the requirements for the Degree of Doctor of Philosophy Department of Psychology Advisor: Amy E. Naugle, Ph.D.

Western Michigan University
Kalamazoo, Michigan
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The current study seeks to examine the program operations and treatment practices of individuals and organizations providing equine-assisted therapy services nationwide. Currently, there are several hundred programs across the United States that utilize equine-assisted therapy to treat common mental health problems in children, adolescents, and adults. Not all equine therapy programs function under the same theoretical model and therefore do not deliver treatment services using equivalent principles or techniques. In addition, program policies, procedures, and ethical guidelines of each provider vary. To date, there exists a paucity of research regarding equine-assisted therapy including both qualitative and quantitative data.

The present study was designed to address this lack of knowledge by surveying treatment providers and organizations that offer equine-assisted therapy to individuals with mental health concerns nationwide. It was expected that systematic assessment of these programs would expand the understanding of current equine-assisted therapy practices with focus on identifying barriers and solutions to effective treatment delivery; evaluating the existence of internally consistent treatment concepts and
techniques; measuring adherence of actual treatment delivery to training protocols; and determining if and how programs use standardized outcome measures in their practice.
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Erica Jex Gergely
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INTRODUCTION

Over the past few decades there has been increasing attention directed toward the development and implementation of evidence based practices in psychology. According to the American Psychological Association (APA), “Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273). To begin the process of EBPP, a clinician must determine what research evidence will assist him or her in achieving the best possible outcome for individual clients. As part of this decision-making model empirically supported treatments (ESTs), interventions that have been shown to be efficacious for particular disorders, are often pursued and employed by clinicians. A valuable resource for this approach is a list of empirically validated therapies (subsequently renamed “empirically supported therapies” and more recently termed “research-supported treatments”) originally published in 1995 via a report by the APA’s Division 12 Task Force on the Promotion and Dissemination of Psychological Procedures (“Task Force”). The initial and now illustrious ESTs list provided 25 examples of psychological interventions that met the Task Force’s criteria for empirical support in treating children, adolescents, and adults (Woody, Weisz, & McLean, 2005). As additional research evidence is reviewed and evaluated, the list, now available online
through Division 12’s website (see http://www.div12.org/PsychologicalTreatments/index.html), is revised and updated.

In determining which treatments meet the Task Force’s criteria for sufficient evidence of efficacy, separate hierarchical categories have been established: *strong research support/well-established treatments, modest research support/probably efficacious treatments, experimental treatments, and controversial treatments.*

Specifically, for an intervention to fit into the *strong research support* classification or to be proclaimed *well-established* it must have been subject to (1) at least two good group design studies, conducted by different investigators, demonstrating efficacy by being superior to pill or psychological placebo or to another treatment; or equivalent to an already established treatment in studies with adequate statistical power, or (2) a large series of single case design studies demonstrating efficacy with good experimental designs and with a comparison of the treatment to pill, psychological placebo, or another treatment. These studies must also have been (3) conducted with treatment manuals, and (4) characteristics of the client samples must have been clearly specified.

In order to meet criteria for *modest research support/probably efficacious treatments* the intervention must have undergone one of the following: (1) two studies showing the treatment is more effective to a wait-list control group; (2) two studies otherwise meeting the well-established treatment criteria 1, 2, and 4, but both are conducted by the same investigator, or one good study demonstrating effectiveness by these same criteria; (3) at least two good studies demonstrating effectiveness but flawed by
heterogeneity of the client samples; or (4) a small series of single case design studies otherwise meeting the well-established treatment criteria 2, 3, and 4 (Task Force, 1995). Furthermore, treatments that have not yet been established as at least probably efficacious are considered experimental (Task Force, 1995) and those that yield conflicting results or are considered efficacious but claims about why the treatment works are at odds with the research evidence are considered controversial (Society of Clinical Psychology, APA Division 12, n.d.).

A review of the current list of Research-Supported Treatments is available on the website of the Society for Clinical Psychology (see http://www.div12.org/PsychologicalTreatments/treatments.html) and includes 60 psychological interventions for which there is evidence to support their efficacy for particular disorders. A closer examination of these interventions confirms that the specific clinical techniques that comprise most ESTs appear to be drawn from a relatively limited number of procedures, most of which are practiced in cognitive and behavioral therapies (“Myths and Facts,” n.d.). In essence, the most commonly used evidence-based approaches for the treatment of psychological symptoms involve cognitive and behavioral therapies (CBT) and the efficacy of CBT has been demonstrated for a wide-range of symptoms in adults, adolescents, and children (“What is Cognitive Behavior Therapy?,” n.d.). According to a review in 2001 (Chambless & Ollendick, 2001), approximately 80% of the treatments for specific disorders (for both adults and children) characterized as having research
support fall within the CBT class (as reported in “What is Cognitive Behavior Therapy?,” n.d.).

Specifically, the core features of CBT include a collaborative, goal-oriented, structured, time-limited approach (typically 6-20 sessions) that focuses on teaching clients specific skills (and practicing these skills inside and outside of sessions); the interrelationship between thoughts, emotions, and behaviors; the resolution of present-day problems; and involves continual assessment of progress toward treatment goals. Common treatment strategies for CBT include cognitive-restructuring, mindfulness techniques, relaxation and stress-reduction exercises, problem-solving and decision-making skills training, avoidance-prevention, emotion regulation skills training, and activity-scheduling, among others.

Although traditional psychological interventions that use these cognitive and behavioral techniques have shown to be efficacious, empirical evidence is not always available to support the efficacy or effectiveness of every treatment that utilizes these methods, including newly emerging, unconventional modalities. Innovative therapies that employ effective ingredients commonly found in ESTs combined with unique, nontraditional elements have the potential to augment existing outcome results and provide positive ancillary or side benefits. Moreover, the value of conducting research on experimental treatments, those not yet shown to be at least probably efficacious, has been particularly encouraged by the APA’s Task Force (1995). Further, the Task Force noted that because of the fluid nature of the categorical system of efficacy, treatments
can shift from one category to another dependent on the empirical support that develops for that treatment over time (as reported in Ollendick & King, 2004). Relatedly, the National Institute of Health, in their publication on unconventional medical treatments (1992), cautioned researchers to avoid the scientific pitfall of rejecting innovative treatments without fair examination of their potential. Likewise, the American Psychiatric Association’s Committee on Research and New Treatments asserts that “while we acknowledge the usefulness of conventional treatments in psychiatry, it is also important to consider alternative or integrative approaches ... it is important to add to the armamentarium of conventional pharmacological treatments and to educate psychiatrists and mental health professionals about a range of evidence-based complementary, alternative, and integrative approaches” (as reported in Moran, 2005, p. 40).

As the call for EBPP increases, it is prudent for clinicians and consumers to be cautious when there exists a dearth of research for a given intervention; however, it is important to draw the distinction between unvalidated treatments (i.e., those that have not yet been adequately researched) and invalidated treatments (i.e., those that have been researched and shown not to work) or treatments that could be classified as pseudoscience (“Myths and Facts,” n.d.). The potential value of a treatment should not be diminished or discarded without sufficient empirical investigation.

Collectively, this information conveys the importance and utility of researching experimental, nontraditional modalities that incorporate evidence-based techniques
into their practice. The possible benefits of a new therapy approach remain unknown until it is adequately scrutinized by the greater scientific community. The present study aims to expand upon the existing knowledge base of one such experimental intervention known as equine-assisted psychotherapy (EAP), by examining the program operations and treatment practices of organizations providing this and similar equine-therapy services around the country.

**EAGALA-Model Equine-Assisted Psychotherapy (EAP)**

There are several variations of equine-assisted therapy in practice today, all of which have distinct guidelines, standards, and theoretical foundations that underlie their mission. Some of the more popular versions include: equine-facilitated learning (EFL), equine-facilitated therapy (EFT), equine-facilitated psychotherapy (EFP), equine-facilitated mental health (EFMH), equine-assisted experiential therapy (EAET), equine-assisted counseling (EAC), equine-assisted learning (EAL), and equine-assisted psychotherapy (EAP). Organizations such as the Equine Facilitated Mental Health Association (EFMH), the Professional Association of Therapeutic Horsemanship (PATH) International (formerly known as the North American Riding for the Handicapped Association-NARHA), and the Equine Assisted Growth and Learning Association (EAGALA) are among the largest associations that offer training and accreditation in the use of their specific model of equine therapy. While information will be collected from individuals who provide various forms of equine-assisted therapy, a major focus of this
study will be on EAGALA-model EAP in particular. EAGALA is a not-for-profit organization dedicated to improving the mental health of individuals, families, and groups around the world by setting the standard of excellence in EAP and provides education, standards, innovation, and support to professionals providing these services (EAGALA, 2010).

EAGALA-model EAP is experiential in nature and incorporates ground-work with horses into the therapeutic environment in an effort to promote emotional growth and learning. To this end, clients engage in hands-on activities with horses designed to: promote self-awareness and self-control; enhance social, emotional, and behavioral skills development; and identify and alter maladaptive thinking and behavior patterns that negatively affect functioning. Further, sessions include an intensive processing component intended to encourage exploration of the thoughts, feelings, and behaviors that emerge during treatment and a discussion of how this information can assist clients in attaining their treatment goals. Using strategies to promote generalization, therapists assist clients in transferring newly learned knowledge and skills from the therapy setting to real-life situations. Sessions are facilitated through a collaborative effort between a licensed mental health professional (MHP) and an equine specialist (ES).

EAGALA-model EAP has been characterized as a “metatheoretical” method, as it does not rely on a specific psychotherapeutic belief system; rather, it defines a structure within which clinicians may apply their chosen theories (Karol, 2007). Notwithstanding this flexibility, internally consistent treatment concepts and techniques exist within the EAGALA-model training protocol.
Possible Mechanisms of Change in EAGALA-Model EAP

Effective generalization of knowledge, skills, and abilities is believed to be a key mechanism of change in EAP. One important technique used to facilitate the transfer of skills, and thus create positive change, is therapeutic metaphor. Use of valuable metaphors within sessions can be an effective catalyst for producing change in aspects of [a clients’] life outside the arena (EAGALA, n.d.). “The essence of metaphor is understanding and experiencing one kind of thing in terms of another” (Lakoff & Johnson, 1980, p. 5). Metaphors, then, are vehicles for understanding, designed to mediate what is known and what is unknown (as reported in Reisfield & Wilson, 2004). Further, use of metaphoric speech eases and assists communication, thereby serving as a powerful tool for establishing a consensual understanding in the therapeutic relationship, and influencing the client experience in ways that promote adaptation and positive self-regard (Sims, 2003).

Research in the broader field of experiential therapy and on the psychotherapy process itself seems to support re-emphasizing clients' metaphors (Greenberg, Rice, & Elliott, 1993; McMullen, 1989; Pollio & Barlow, 1975; Toukmanian, 1994) as a means for understanding the mindsets that underlie their actions (Schon, 1993). Therefore, EAP treatment staff listens for, creates, and evokes metaphors that may provide insight into the cognitive, affective, and behavioral underpinnings of the client’s life experience (Reisfield & Wilson, 2004). Metaphoric learning is prompted through participation in instructional activities involving horses. These opportunities allow clients to explore and
reflect upon their own thoughts, feelings, and behaviors (and their consequences) and to develop referential meaning that aids in personal growth and learning. Further, the use of metaphor provides the client with an opportunity to alter his or her perception of a problem or situation, which often yields to the generation of new solutions (Wickman, Daniels, White, & Fesmire, 1999) and fosters positive therapeutic change.

Two types of therapeutic metaphor models most commonly used in this modality are nondirective and directive. Nondirective metaphors are created naturally by the client or are prompted by the therapist and are generally based on analogies between their in-the-moment experiences with horse(s) and real-life situations (EAGALA, 2012). “Clients devise their own metaphors based on things they know and value, and are thus able to arrange their experiences in personally meaningful ways” (Reisfeld & Wilson, 2004). Directive metaphors are deliberately set up by the facilitators to match the client’s treatment goals and use horses as a central part of the construct (EAGALA, 2012).

Action research suggests that in an effort to promote insight and provoke change through metaphor, facilitators should establish a context in which participants can get stuck, reflect on their “stuckness,” and take responsibility for learning how to become unstuck (Argyris, Putnam, & McLain-Smith, 1985). With this objective in mind, clients of EAGALA-model EAP are often asked to partner with horses and engage in role-playing situations in which particular skills are practiced in an effort to accomplish a given task. Over time, in their quest to complete these tasks, clients typically develop mutually
trusting, respectful relationships with the horses creating a safe environment that engenders change. These role-playing experiences give clients considerable opportunity to learn and practice new skills and to rehearse behaviors relevant to their real-life, current problems. “For example, the need to communicate with a horse calmly and non-reactively promotes the skills of emotional awareness, emotion regulation, self-control, and impulse modulation” (Marx & Cumella, 2003, p. 144). It is the therapist’s responsibility to assist clients in assimilating newly learned skills and behaviors into their daily lives and to continuously assess progress toward treatment goals. Horses and treatment staff provide the client with positive reinforcement through verbal and nonverbal feedback, attention, approval, and reward as their role-play behaviors become more constructive, effective, and skilled.

A strong belief held within EAGALA-model EAP is that clients’ daily life problems often show up in relationships with others, including the horses, and provide useful information for treatment staff who keenly observe these horse-human interactions. “It is assumed that behaviors that don’t elicit a positive response from the horse are causing similar problems in other areas of the client’s life” (Shultz, 2005, p. 21). Consequently, because horses are known to respond in direct relation to and in accordance with the behavior exuded by humans, they can serve as punishers (i.e., aversive stimuli) when assisting clients in accomplishing an experiential activity. For example, if a client behaves in an aggressive, confrontational, or otherwise aversive manner toward a horse, treatment provider, or group member, the horse is likely to
respond in an equally aversive manner by being unwilling to move, by invading the client’s space, or by nudging, bumping, or nipping at him or her. In other words, when clients engage in maladaptive, undesirable behaviors, the horse “mirrors” their response and prevents them from accomplishing the assigned task. In turn, the future likelihood and frequency with which clients engage in these same unproductive behaviors are decreased. It is the role of the equine specialist to help clients change their undesirable behaviors into more skillful and effective behaviors in an effort to elicit positive responses from the horse, while the therapist helps the client to transfer this learning to other relationships and aspects of their lives (Shultz, 2005). In essence, what is learned through experiential activities in EAP is that in order to become “unstuck” in life, the client must become aware of the consequences of his or her actions, take responsibility for those actions, and change themselves (i.e., their thoughts, feelings, attitudes, behaviors) to elicit positive changes from their environment. This is a potent metaphor likely to have great application in a client’s everyday life and can be learned quickly, when introduced in a non-punitive manner through interactions with horses.

Another key element postulated to be a mechanism of change within EAGALA-model EAP is the phenomenon whereby clients can transfer, project, or label their thoughts, feelings, emotions, and experiences onto horse(s), objects, and experiential activities. Oftentimes during therapy, clients will assign labels to a horse who may remind them of a person, place, thing, or obstacle in their lives. By continuing to address the horse with the client’s label and allowing him or her to process in-session
experiences using this association, a stimulus equivalence or relational frame is formed and can be a valuable and effective therapy agent. Further, during a therapy session the client may be asked to choose one or more horses and traverse through an obstacle course complete with barriers, jumps, and feed buckets until he or she reaches the finish line. After completing the task, the client may indicate autonomously or be asked by the therapist to describe who the horse represented in the activity (e.g., themselves, their parents, teachers, peers), what the feed buckets, which were likely to distract the horse(s) from their task, represented (e.g., drugs, alcohol, peer-rejection, history of abuse), or what the obstacle course represented (e.g., their journey in life or their path to psychological stabilization). Behaviorally, this type of phenomenon may be considered an “extended” or “abstract” tact, whereby “a verbal operant in which a response of a given form is evoked (or at least strengthened) by a particular object or event or property of an object or event” (Skinner, 1957, pp. 81-82).

This tendency toward anthropomorphism or personification in EAGALA-model EAP offers a unique therapeutic advantage that allows clients to discover insights, uncover learning histories, and identify ineffective behavioral patterns in-the-moment through external sources, as opposed to learning through introspection, abstract thinking, and retrospection, typical in many forms of traditional office-based therapy. In a manner comparable to mindfulness, clients bring their complete attention and awareness to present experiences, which helps to bypass their propensity toward experiential avoidance and the contexts that elicit this behavior by talking about
themselves and real-life situations through the horse(s). This ability to project internal experiences onto living and inanimate objects also allows the client to feel less vulnerable and more open to recognizing his or her own behaviors, which ultimately can lead to positive change.

The experiential processing component found in EAGALA-model EAP is another essential change element. Processing can be thought of as the therapeutic discourse and engagement that provides opportunity and space for meaning, reflection, understanding, and applicability between the in-session equine-assisted experience and the client’s real-life (EAGALA, 2012). To this end, treatment providers must carefully observe the content, process, and various other dynamics involved in the therapy session and present selected observations to clients using clean, objective language to promote a deeper level of exploration, learning, and personal growth. To assist treatment providers in effective observation, EAGALA developed a framework where facilitators are trained to watch for Shifts or Patterns in client(s) or horse(s) behavior, Unique therapy moments, Discrepancy between client’s verbal and nonverbal behavior, and to be Self-aware of their own biases that may inadvertently impact treatment. The acronym SPUD’s is used to communicate these essential EAGALA-model observational components.
Empirically Supported Methods Employed in EAGALA-Model EAP

Throughout the EAGALA-model EAP process clients are consistently trained to recognize the interrelationship between their thoughts, feelings, and behaviors. As such, they become more aware of thought distortions underlying their psychological impairment and helping to reinforce their negative behaviors. By exploring and processing these patterns externally through activities with horses, clients can describe their emotions accurately, identify and correct their distortions, and develop more positive coping strategies to improve their general functioning. In other words, activities promote a change in thinking, which promotes a change in behavior (Aspen Education Group, 2009). For these reasons, EAGALA-model EAP can be regarded as CBT in nature.

Partnering with horses through the therapy process serves many functions. They provide nonjudgmental, concrete feedback for behaviors; they serve as a vehicle to propel the client toward growth and learning; they are a source of inspirational imagery and are often a source of pleasure, which helps to maintain motivation for treatment; they offer vast opportunities for metaphorical learning; their size, power, and stature add an element of challenge, unpredictability, and empowerment to each session; and they are social creatures with defined roles in their herd, allowing endless analogies to human behavior. Horses add another relational dimension to the therapeutic experience. Elements of teamwork, cooperation, communication, successful challenge, healthy competition, and improved socialization are all easily introduced and coordinated, using the horse as a medium (Tyler, 1994, p. 145).
Like human behavior, horse behavior can be best understood through observation. Derived from their biological history of being prey animals, horses have developed intense, unconditioned responses to threatening situations. Their immediate reaction to real or perceived threat is to flee, although they will stand their ground and defend themselves or their offspring in cases where flight is untenable (Kinsey & Denison, 2008). This behavior is analogous to the unconditioned and conditioned responses of humans who commonly seek to escape and avoid emotionally or physically threatening situations (i.e., aversive stimuli and/or conditions), whether real or based on faulty appraisal. For horses, survival dictates that they exist as members of a herd, who stick together and cooperate with one another (New World Encyclopedia, 2008), a socialization and adaptation strategy similar to that of humans. Within their herd, a social hierarchy, or “pecking order,” is established through communal interaction and is based on avoidance strategies and survival-contingent behaviors. In a parallel, metaphoric-manner, many of the clients seen in EAP work have already been thoroughly driven away from the human herd, and rather than repeating this experience and risking further psychological harm, we move directly to “join up” with them on a path toward growth and learning via the “almighty equine” (Miller, 2000).

The ability of horses to form companionship attachments extends to other species, including humans. Since their domestication, horses have been known to work in cooperation with humans. Mutual collaboration is based on natural curiosity and strong social bonds present in both the horse and human. It has been suggested that
“our desire to understand the horse is nothing more than a desire to understand ourselves and the people around us” (Miller, 2000, p. 291). This philosophy is firmly embodied in the beliefs underlying EAGALA-model EAP.

Involvement in therapeutic activities with horses introduces new skills and encourages the maintenance of pre-existing adaptive behaviors in the client’s repertoire. The overarching beliefs in this modality are strength-based and solution-focused. Basic governing principles include the idea that all individuals have strengths, and that focus on these strengths (as opposed to weaknesses) will lead to enhanced motivation for change and improved performance in treatment. In this regard, deficient abilities and failure to demonstrate skills are viewed as opportunities for growth and learning (The Center for Human Services, 2009). Further, the EAGALA model rests firmly on the notion that clients are capable of discovering their own best solutions to life’s problems both inside and outside of the arena. It is the objective of treatment staff to help provide the client with an experiential opportunity where discovery can occur naturally. “The goal is to not only help the client solve the problem at hand, but also to help him or her discover a process of problem-solving applicable in future dilemmas. EAP provides a medium through which clients can realize this process and then specifically apply it to their lives” (Shultz, 2005, p. 23).

Therefore, the process involved in an activity (i.e., how clients respond, engage, and react to the experience) is more valuable than the content or the outcome (Mandrell, 2006). Task success is not the ultimate goal of a treatment session; the
growth and learning that occur during the journey is paramount. If the treatment staff become too focused on success, they are likely to engage in growth-interfering behaviors such as rescuing the client, controlling the client, working harder than the client, becoming confrontational with the client, or judging, criticizing or blaming the client. To create an effective learning experience, therapists must “trust the process” between the horse(s) and the client(s) and allow successes as well as failures, frustrations, and discouragements to happen naturally. Through the use of therapeutic techniques, such as reflective listening, process-oriented questioning, metaphorical communication, objective observation statements, and Socratic questioning, treatment staff gently guide clients toward finding their own solutions, reaching their treatment goals, and, ultimately, improving their functioning.

Literature has suggested that “the setting or context in which treatment is delivered may influence the process and outcome of intervention” (Kolko et al., 2009). In addition, it is believed that variation of the treatment setting may be relevant to address central features of clinical dysfunction or to harness influences (e.g., peers) that may promote therapeutic change (Kazdin, 1996, p. 92). This concept seems particularly germane to EAP, where sessions take place, not in a traditional therapy office but within a barn, arena, or other enclosed structure. Introducing therapeutic work with horses to a person accustomed to conventional, office-based therapy is in itself a change and perhaps a necessary component for treatment success. Fundamentally, EAP provides a unique atmosphere for clients to learn and grow in a positive direction.
Review of Existing Literature

Since even the most empirically well-established treatments don’t “work” for all disorders or all clients, utilizing animals as adjuncts to therapy may offer a viable and novel intervention alternative (Mallon, 1992). Although the field of equine-assisted therapy is still in its infancy and empirical support for this modality is limited, there are some notable studies within the literature that support the therapeutic value of incorporating horses into the therapy situation.

In a comparative analysis the efficacy of group equine-assisted counseling (EAC) and classroom-based counseling with youth at risk for academic and/or social failure was investigated (Trotter, Chandler, Goodwin-Bond, & Casey, 2008). After 12 weekly sessions, students in the EAC group showed statistically significant improvement in 17 behavior areas measured by the Behavioral Assessment System for Children (BASC) and the Psychosocial Session Form (PSF), as compared to significant improvement in only five areas with students in classroom-based counseling. EAC participants’ social skills also showed statistically significant improvement including increases in positive behaviors and decreases in negative behaviors (Trotter et al., 2008). It should be noted, however, that the EAC intervention used in this study included elements of traditional talk therapy, group processing, equine-based therapy activities, and complementary adventure-based therapy activities. As a result of these mixed treatment modalities there are limits to the study’s internal validity. Specifically, it is difficult to determine whether or not equine-assisted activities were responsible for the notable changes.
MacDonald and her colleagues (as presented in MacDonald, 2004) explored the effectiveness of equine-facilitated therapy (EFT) with 126 at-risk adolescents aged 8 to 17 who participated in five existing equine-facilitated programs. While the components of each program varied, all five focused on improving participants’ self-esteem, locus of control, empathy and management of aggression, and reducing their symptoms of depression and loneliness. Although there were no statistically significant differences found on pre and post-measures of these constructs, an individual evaluation of the five EFT programs yielded statistically significant results. For example, increases in self-esteem and internal locus of control, as well as considerable decreases in hostility and aggression were found among individual programs (MacDonald, 2004).

In an open clinical trial, researchers (Klontz, Bivens, Leinart, & Klontz, 2007) examined the effectiveness of a group equine-assisted experiential therapy (EAET) program with residents of a mental health day-treatment facility. After 28 hours of EAET, a statistically significant decrease in general symptom severity and enhancements in psychological well-being were found. These effects were maintained at a six-month follow-up assessment.

In another study, the therapeutic outcome of EAP in treating at-risk adolescents aged 12-18 was evaluated and yielded promising results (Shultz, 2005). Specifically, “there was a statistically significant change in overall psychosocial functioning in the positive direction for those participating in an EAP program,” as indicated on the Youth Outcome Questionnaire parent and self-report forms (Shultz, 2005).
Further, the effectiveness of a 10-week EAP program on improving classroom behavior in 10 students diagnosed as having Emotional Disorders was conducted in a special education setting (Tetreault, 2006). According to participants’ classroom teacher’s report on a researcher-developed measure, students showed a statistically significant improvement in their overall behavior. In addition to learning how to identify and manage their behavior more effectively, participants also gained valuable communication and social skills through their involvement in EAP services.

The efficacy of individual EAP was tested in a cross-sectional group of children with various behavioral and mental health issues and results suggested a statistically significant increase in the participants’ Global Assessment of Functioning (GAF) ratings from pre- to post-treatment. A statistically significant correlation was found between the percentage of improvement in GAF scores and the number of EAP sessions attended (Schultz, Remick-Barlow, & Robbins, 2007).

The effects of a nine-week equine facilitated program for youth with severe emotional disorders who attended an alternative day school were evaluated by Ewing, MacDonald, Taylor, and Bowers (2007). As part of this study, 36 middle and high school students completed instruments that measured their self-esteem, empathy, locus of control, depression, and loneliness. Although no statistically significant differences were found on these quantitative assessments, qualitative data (i.e., interviews and observations) from participants’ special education teacher, therapeutic riding instructor, and volunteer service providers suggested improvements in self-care, a more positive
attitude, increased openness, and improved social skills among participants of the program when compared to the control group.

Recently, outcomes of Equine Facilitated Psychotherapy were examined on self-image, self-control, trust and general life satisfaction in a group of adolescents at a residential treatment facility in Israel. Weekly individual EFP sessions were conducted with the treatment group over the course of seven months and a matched comparison control group was limited to exposure to horses only during agricultural studies and leisure time. Results showed a trend of positive change in all four constructs (i.e., self-image, self-control, trust, and general life satisfaction) within the treatment group on pre and post-test measures (Bachi, Terkel, & Teichman, 2012).

The aforementioned studies examine a variety of equine-assisted therapy modalities used to treat individuals with a broad range of clinical and psychosocial concerns, and yielded varying results. Consequently, further research is necessary to determine whether or not specific models of equine-assisted therapy are viable interventions to treat particular disorders and psychosocial concerns in certain client populations. As a prerequisite to sophisticated empirical study, however, the development of an accurate description of the individual treatment, its underlying theoretical principles, and its essential therapy features is needed.
Problem Statement

Currently, there exist little systematic data about equine-assisted therapy programming nationwide. This research serves as an exploratory, descriptive study about the major components of equine-assisted therapy programs including those related to service implementation, use of evidence-based practices, use of standardized outcome measures, fidelity to training protocols, and various other factors.

METHOD

Participants

Phase I

Treatment providers from several hundred equine-assisted therapy programs across the United States were recruited for Phase I of the study, which involved an extensive web-based survey (see Appendix A). Potential participants were identified through Internet sources and member databases of various national equine therapy organizations. A return rate of 20-30% was expected based on what the literature suggests is typical for web-based surveys. Participants were recruited via e-mail, mailed letter, and/or media-based invitation describing the study and its goals (see Appendix B). A general follow-up contact (see Appendix C) was sent via email, mailed letter, or media-based invitation as an additional means of recruiting participants 3-4 weeks after the original invitation was sent. Within the original invitation and follow up a link to the
web-based survey was provided. Participants interested in learning more about and possibly enrolling in the study were asked to access the survey at their convenience using the web link provided. Prior to beginning the survey, potential participants were asked to read the on-line informed consent documents. As stated in the invitations, participants implicitly offered their consent by submitting to use their anonymous responses to the survey. Those who did not wish to partake in the survey were instructed to simply disregard the invitation or exit the survey and their data were not collected. At the end of the web-based survey, participants were provided with basic information regarding Phase II of the study and were asked to indicate whether or not they were interested in hearing additional details from the research investigator. Those who were interested in learning more were asked to provide their contact information, which was stored separately from their anonymous survey responses, in order for the researcher to follow up regarding Phase II study details.

Of the approximately 600 individuals recruited to participate in the 65-item web-based survey, data from 207 responders were collected (~34.5% response rate). Of the 207 responders, 16 indicated they were not equine-assisted therapy service providers and were therefore bounced to the end of the survey. The remaining 191 responders who indicated they were equine-assisted therapy service providers were asked to continue the survey.
Phase II

Those participants who indicated (via Phase I) their interest in learning more about Phase II of the study, which involved collecting treatment integrity data during their equine therapy sessions, were asked to provide their contact information to the researcher via an online form at the end of the Phase I survey. This contact information was collected and stored separately from their anonymous Phase I survey responses. These participants were then contacted by the researcher via their provided telephone, email, and/or post mail address with further explanation of the details for Phase II (see Appendix D). They were also provided with a consent form via email, fax, or post mail and those who were interested in enrolling in Phase II returned the completed consent to the researcher. Once consent was established the researcher provided participants with the material/equipment needed for data collection and additional information regarding their involvement. In order to be eligible for Phase II, participants were required to practice EAGALA-model EAP, specifically.

Of the 63 Phase I participants who indicated their interest in learning more about Phase II of the study, nine EAGALA-model EAP treatment teams (i.e., MHP and ES) from six separate organizations across the country agreed to participate, and successfully collected data from 20 EAGALA-model EAP sessions. It should be noted that several other individuals agreed to participate, but were either ineligible or unable due to their equine-assisted therapy services being non-EAGALA model or their lack of consistent client-base. Further, many individuals who initially showed interest in Phase II
did not follow up with the researcher after receiving additional details regarding the study.

**Setting**

**Phase I**

Participants who agreed to complete the web-based survey were asked to do so at a computer and location of their choice. A direct link to the survey web site was provided in their study invitation. Participation in this phase of the study was anonymous; no names were attached to the survey responses.

**Phase II**

Participants who indicated their interest in learning more about Phase II of the study were contacted by the research investigator and provided with additional details regarding their involvement. Participants were asked to audiotape up to three EAP sessions at their natural location; recording equipment was loaned to participants by the researcher. Following these recorded sessions, participants were asked to complete the Equine-Assisted Psychotherapy Treatment Integrity Checklist (EAP-TIC) (see Appendix G), a paper-based form, designed to assess the level of adherence of actual EAP treatment delivery to EAGALA-model training standards. Participants were also asked to complete a brief descriptive questionnaire featuring ten items from the Phase I survey (e.g., educational background and training, years of experience in equine-
assisted therapy, treatment setting, clinical populations most commonly worked with, etc.). Finally, participants were provided with a ‘permission to record’ document that they were asked to sign after reviewing it with their EAP clients and parent(s)/guardian(s) if needed (see Appendix F). The EAP-TIC, descriptive questionnaire, permission to record document, and recording equipment were mailed directly to the program director and returned to the research investigator in a provided postage-paid envelope immediately following completion.

Procedure

Phase I

A list of contact information for equine therapy programs throughout the United States was generated using online resources such as the EAGALA, EFMHA, and NARHA websites and broad internet searches. Emails and letters were sent to staff of these organizations describing the study, its purpose, and what participation might entail (see Appendix B). A general follow-up contact (see Appendix C) was sent via email, mailed letter, or media-based invitation as an additional means of recruiting participants three to four weeks after the original invitation was sent.

Non-probability (i.e., convenience) sampling methodology was used, via a web-based survey, to collect data from a subset of equine therapy service providers in the United States. The survey was launched on December 11, 2011 and was closed to participants on February 14, 2012. The primary goal of Phase I was to gather
information on the program operations and treatment practices of individuals and organizations providing equine therapy services nationwide. Participants were asked to provide responses to open and closed-ended questions regarding their provision of equine therapy services.

**Phase II**

EAGALA-model EAP participants who completed Phase I of the study and indicated their interest in learning more about Phase II were contacted by the researcher with additional details. The primary objective of Phase II was to rate the frequency with which various therapist-related behaviors occurred during the EAGALA-model EAP session, using the EAP-TIC. In order to do this, participants were asked to audio record up to three treatment sessions with clients who agreed to have their sessions recorded. The EAP clients were not the primary focus of data collection; data from the clients themselves were not collected or analyzed.

After participants returned Phase II data, the researcher and trained independent observers (i.e., two undergraduate and one graduate research assistants) reviewed the audio recordings and completed the EAP-TIC based on the information captured during the recorded session. Self-report data from participants EAP-TIC ratings and those of the independent observers were compared to determine agreement of scoring on each component of the checklist. These data were used to assess the reliability and utility of the EAP-TIC as a treatment integrity measure and to assess the
level of adherence of actual EAP treatment delivery to the EAGALA-model training standards in programs across the United States. Participants were not asked to identify themselves on the assessment materials; however, their mailing address and organization name was known to the researcher. Again, there was no identifying information gathered about the clients being recorded by participants.

Independent observers were two undergraduate and one graduate research assistant trained by the researcher in how to rate the frequency with which particular therapist behaviors and skills occurred during equine therapy sessions using the EAP-TIC. Training was accomplished by thoroughly reviewing the EAP-TIC components, clarifying the information being collected, and providing examples of what behaviors and skills were to be rated. Research assistants practiced their use of the EAP-TIC until reasonable understanding was reached, per researcher.

Materials

Phase I

Participants were asked to anonymously complete a detailed web-based survey regarding various aspects of equine therapy programming at the location where they provide these services. The survey was designed specifically for this study and focused on characteristics of service implementation, use of evidence-based practices, use of standardized outcome measures, fidelity to training protocols, client demographic information, and other program-related factors.
Phase II

Phase I completers who provide EAGALA-model EAP and offered their contact information in order to learn more about Phase II received an e-mail or telephone call from the researcher with additional information regarding the final segment of the study, its purpose, and what their involvement would entail. Those interested in participating in Phase II were asked to complete the informed consent process and were subsequently provided with recording equipment and paper copies of the EAP-TIC and descriptive questionnaire. Participants were asked to record up to three EAGALA-model EAP sessions during the time the equipment was loaned to them and were asked to complete the EAP-TIC following each recorded session. All sessions were digitally audio-recorded on separate memory cards using the equipment provided by the researcher (i.e., ZOOM H4 Handy Recorder). After completing each EAP-TIC, participants were asked to place it in a provided envelope along with the memory card of that particular recorded session. The EAP-TIC forms, descriptive questionnaires, and memory cards were pre-coded by the researcher to preserve participant identification and keep needed materials together. After participants completed collecting data, all materials were mailed directly to the researcher in provided prepaid envelopes.
Analysis

Phase I

Descriptive statistics, including frequencies, percentages, means and standard deviations were calculated to describe the treatment practices and services provided by participating individuals and organizations. In addition, responses from individuals and organizations were coded on variables such as client demographics, characteristics of treatment implementation, use of evidence-based practices, use of standardized outcome measures, and other program-related factors. Theoretical orientations of participants were correlated to their description of services provided, procedures endorsed, and perceived function of the horse in treatment using cross tabulations and T-tests, when appropriate.

Phase II

The EAP-TIC was designed to capture behaviors assumed by the researcher to be critical in performing adherent, competent EAGALA-model EAP, based on information presented in the EAGALA training manual, Level I and II EAGALA training courses, and available EAGALA literature. The EAP-TIC provides a measurement of conformity with 13 prescribed elements and the absence of five proscribed elements of EAGALA-model EAP during sessions delivered by trained providers. In addition to these 18 items, the EAP-TIC also includes four items that require users to subjectively rate how much their
client(s) engaged in the therapy process, appeared to value the treatment, were able to relate in-session experiences to their life, and/or expressed oppositional behavior during their EAP session. Ultimately, the self-report data from participants’ EAP-TICs and the EAP-TIC ratings from the researcher and independent observers (i.e., research assistants) were compared to determine agreement of scoring on each component of the checklist. The student investigator coded all 20 audio sessions. Fifty percent of the audio recordings were randomly selected and coded by the independent observers. It was decided a priori to retain frequency counts for all 18 EAP-TIC behaviors but that the data would be collapsed into dichotomous categories (i.e., occurred versus did not occur) for analysis of agreement.

RESULTS

Phase I

Since participants could not be required to answer every question included in the survey, many chose not to answer multiple questions. Data are presented based on the number of responses collected for each individual question. Descriptive statistics (e.g., frequencies, percentages, means, and standard deviations) were generated for applicable survey questions. Content from open-ended, qualitative questions were analyzed to identify possible trends, themes or categories found among responses. Further, contingency tables are used to display the multivariate frequency distribution of different variables to show their relationship. Phase I results are separated into two
categories based on how they were presented to participants in the web-based survey. The first category includes information obtained from Part I of the survey, which referred to the participant as an individual equine therapy service provider, while the second category (i.e., Part II) features information about the agency/organization/practice in which the participant works as an equine therapy service provider.

**Part I**

To obtain a better understanding of the population of interest (i.e., equine-assisted therapy service providers within the United States) survey takers were asked to provide information on the type of equine therapy they provide, years of experience in that modality, education and training background, membership to EAGALA (if applicable), profession, and treatment setting. Of the 191 equine-assisted therapy treatment providers participating in the survey, 187 reported the type(s) of equine therapy services they personally provide (note that many responders practice multiple equine therapy approaches and therefore selected more than one choice). The most commonly practiced approach was EAGALA-model EAP (72.7%, \( n = 136 \)), followed by Equine Assisted Learning (55.1%, \( n = 103 \)), also an EAGALA approach, and Equine Facilitated Psychotherapy (25.1%, \( n = 47 \)). See Table 1 for complete breakdown of the sample.
Table 1

*Equine-Assisted Therapy Models Practiced by Respondents*

<table>
<thead>
<tr>
<th>Equine-Assisted Therapy Model</th>
<th>Percentages</th>
<th>Frequency (N = 187)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EAGALA-model EAP</td>
<td>72.7%</td>
<td>136</td>
</tr>
<tr>
<td>Non-EAGALA-model EAP</td>
<td>20.3%</td>
<td>38</td>
</tr>
<tr>
<td>Equine Assisted Learning (EAL)</td>
<td>55.1%</td>
<td>103</td>
</tr>
<tr>
<td>Equine Assisted Therapy (EAT)</td>
<td>19.8%</td>
<td>37</td>
</tr>
<tr>
<td>Equine Facilitated Therapy (EFT)</td>
<td>9.6%</td>
<td>18</td>
</tr>
<tr>
<td>Equine Facilitated Psychotherapy (EFP)</td>
<td>25.1%</td>
<td>47</td>
</tr>
<tr>
<td>Equine Assisted Counseling (EAC)</td>
<td>15.5%</td>
<td>29</td>
</tr>
<tr>
<td>Equine Experiential Learning (EEL)</td>
<td>16.6%</td>
<td>31</td>
</tr>
<tr>
<td>Equine Facilitated Learning (EFL)</td>
<td>17.1%</td>
<td>32</td>
</tr>
<tr>
<td>Equine Facilitated Mental Health (EFMH)</td>
<td>10.7%</td>
<td>20</td>
</tr>
<tr>
<td>Equine Assisted Mental Health (EAMH)</td>
<td>9.1%</td>
<td>17</td>
</tr>
<tr>
<td>Equine-Facilitated Growth and Learning (EFG/EFL)</td>
<td>13.9%</td>
<td>26</td>
</tr>
<tr>
<td>Therapeutic Riding</td>
<td>19.8%</td>
<td>37</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>17.1%</td>
<td>32</td>
</tr>
</tbody>
</table>

Of the 136 participants who reported practicing EAGALA-model EAP, 11.7% (n = 16) indicated they completed EAGALA Level I certification training only, 75.2% (n = 103) had accomplished EAGALA Level I and II certification training, and 10.9% (n = 15) had earned their EAGALA Advanced certification. Two participants stated they had not completed any EAGALA certification training, which suggests that the other member of their EAGALA-model EAP treatment team holds at least a Level II certification (i.e., EAGALA requires only one member of the two-person treatment team to be Level II certified). Of those who reported practicing EAGALA-model EAP, 95.6% (n = 130) indicated they were a current member of the EAGALA organization, 4.4% (n = 6) were not EAGALA members at the time of survey completion.
For more information on their professional and educational backgrounds, participants were asked to specify whether they qualified as the mental health professional (MHP) or equine specialist (ES) member of the therapy team, or perhaps were eligible to perform both MHP and ES roles. Forty-five participants (24.1%) indicated they served the role of MHP, 75 (40.1%) qualified as the ES, and 53 (28.3%) were eligible to function as either the MHP or the ES in their equine-assisted therapy team. Fourteen participants (7.5%) reported serving as an “other” team member, which ranged from occupational therapist, to PATH instructor, riding instructor, life coach, social worker and recreation therapist. Identified mental health professionals were asked to give further details about their work, including time spent in traditional, office-based therapy settings versus equine therapy settings and whether or not they mix treatment modalities (i.e., office-based and equine) with clients. Ten MHPs (13.5%) reported they provided equine therapy services exclusively. Eight MHPs (10.8%) stated they own an independent practice where they provide equine therapy services as an adjunct to traditional therapy for the same clients, whereas five other MHPs (6.8%) who own an independent practice and offer both traditional and equine therapy indicated they do not mix modalities with the same clients. Thirty-three MHPs (44.6%) reported owning an independent practice where they sometimes see the same clients for traditional therapy and equine therapy. Eighteen MHPs (24.3%) indicated they worked two separate jobs, one where they function in a traditional therapy setting and the other where they operate within an equine therapy setting. Twenty-seven MHPs
selected the “other” category. Those who offer both modalities of treatment (either to the same clients or different clients within the same practice) were asked to share how they determine or decide which service to provide to which clients. Participants’ responses fit into several general themes (many reported more than one factor).

Twenty-five MHPs (39%) suggested that the decision to pursue traditional versus office-based therapy was based on clients’ interest; 23 MHPs (36%) stated that the treatment modality was determined based on clients’ presenting concerns, diagnosis, or treatment targets; 16 MHPs (25%) indicated that equine therapy was pursued or recommended when clients became “stuck” in traditional, office-based therapy and were no longer making treatment gains; and seven MHPs (11%) reported the decision for which modality to pursue was based on the recommendations of their referral source. Six MHPs (9%) indicated that all their clients pursue equine services at some point during treatment and two responses did not fit any of the categories above nor did they appear to answer the intended question and were therefore placed into an “other” grouping.

Years involved in providing equine therapy services varied among survey respondents. Twelve participants (7.2%) had less than six months of experience, 21 (12.6%) had between six months and one year, 29 (17.4%) had between one and two years, 28 (16.8%) had between two and three years, 28 (16.8%) also had between three and five years, 24 (14.4%) had five to ten, and 25 (15%) participants reported having over 10 years of experience providing equine therapy services. Twenty-four survey takers did not provide a response to this item.
In terms of the highest educational degree obtained by respondents, the largest portion of participants indicated they earned a master’s degree \((n = 82, 50\%)\). Following this, 37 (22.6%) received their bachelor’s degree, 13 (7.3%) hold a doctorate degree, 12 (7%) earned an associate’s degree, and 1 (0.3%) holds a medical degree. Of the 19 participants who selected the “other” category, 1 (0.3%) holds a high school diploma, 1 (0.3%) fits the associate’s degree group, 4 (1.2%) belong to the bachelor’s degree group, 6 (3%) qualify for the master’s degree group, 1 (0.3%) has earned a doctorate degree, and 6 (3%) reported some unknown specialized certification or otherwise invalid response.

Determining which theoretical orientation best informs participants’ clinical approach to equine-assisted therapy was another area of importance in the current study. Survey takers were asked to select the top three theories they draw upon in equine therapy from the list provided or to indicate another unlisted theory using the “other” option. The orientation most commonly selected as one of participants’ top three choices was Experiential \((n = 110)\) with 71 survey takers \((64.5\%)\) identifying this as their primary theory, 29 \((26.4\%)\) selecting it as their secondary, and 10 \((9.1\%)\) as their tertiary. The second most commonly selected orientation was Cognitive Behavioral \((n = 82)\) with 29 \((35.4\%)\) of participants choosing this as their primary theory, 31 \((37.8\%)\) choosing it as their secondary, and 22 \((26.8\%)\) as their tertiary theory. Gestalt was the third most commonly selected orientation \((n = 39)\) with 33.3% \((n = 13)\) of participants indicating this was their primary theoretical orientation, 38.5% \((n = 15)\) reporting it as
their secondary theory, and 28.2% \((n = 11)\) stating it was their tertiary theory of importance. Table 2 shows how many participants selected each theoretical orientation \((N = 150)\), 41 participants chose not to answer this question. The “other” category included the following responses: Jungian, 12-step AA, Lessons from Lakota Way of Life, Trauma-based mixed models, solution focused, brief systemic, mind-body, Family Systems, Dialectical Behavior Therapy, Core Energy Counseling, Sensory Integration, and neuromuscular or neurodevelopmental therapy.

**Table 2**  
*Top Theoretical Orientations Selected by Respondents*

<table>
<thead>
<tr>
<th>Theoretical Orientation</th>
<th>1st ((n))</th>
<th>2nd ((n))</th>
<th>3rd ((n))</th>
<th>((N = 150)) Total Frequency (Percentages)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adlerian</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>8 (5%)</td>
</tr>
<tr>
<td>Behavioral</td>
<td>11</td>
<td>12</td>
<td>13</td>
<td>36 (24%)</td>
</tr>
<tr>
<td>Cognitive</td>
<td>5</td>
<td>8</td>
<td>6</td>
<td>19 (13%)</td>
</tr>
<tr>
<td>Cognitive Behavioral</td>
<td>29</td>
<td>31</td>
<td>22</td>
<td>82 (55%)</td>
</tr>
<tr>
<td>Existential</td>
<td>3</td>
<td>5</td>
<td>8</td>
<td>16 (11%)</td>
</tr>
<tr>
<td>Experiential</td>
<td>71</td>
<td>29</td>
<td>10</td>
<td>110 (73%)</td>
</tr>
<tr>
<td>Eclectic</td>
<td>9</td>
<td>11</td>
<td>10</td>
<td>30 (20%)</td>
</tr>
<tr>
<td>Gestalt</td>
<td>13</td>
<td>15</td>
<td>11</td>
<td>39 (26%)</td>
</tr>
<tr>
<td>Humanistic</td>
<td>9</td>
<td>9</td>
<td>4</td>
<td>22 (15%)</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>6</td>
<td>10</td>
<td>14</td>
<td>30 (20%)</td>
</tr>
<tr>
<td>Psychodynamic</td>
<td>4</td>
<td>7</td>
<td>10</td>
<td>21 (14%)</td>
</tr>
<tr>
<td>Rogerian</td>
<td>7</td>
<td>5</td>
<td>3</td>
<td>15 (10%)</td>
</tr>
<tr>
<td>Transtheoretical</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>7 (5%)</td>
</tr>
<tr>
<td>Faith-Based</td>
<td>11</td>
<td>4</td>
<td>2</td>
<td>17 (11%)</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td>28 (19%)</td>
</tr>
</tbody>
</table>
Participants were asked to indicate the extent to which they used various intervention strategies commonly found in empirically supported treatments during their equine therapy implementation. A five-level Likert scale was used for this question (i.e., 1 = not at all, 2 = to a slight extent, 3 = to a moderate extent, 4 = to a great extent, 5 = to a very great extent). Table 3 shows the full breakdown of results.

Table 3

*Extent to Which Intervention Strategies Commonly Found in Empirically Supported Treatments Are Used by Participants During Equine Therapy Sessions*

<table>
<thead>
<tr>
<th>Treatment Technique</th>
<th>1 Not at All (n)</th>
<th>2 Slight Extent (n)</th>
<th>3 Moderate Extent (n)</th>
<th>4 Great Extent (n)</th>
<th>5 Very Great Extent (n)</th>
<th>Mean (Standard Deviation)</th>
<th>(N = 150) Total Frequencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifying Cognitive Errors</td>
<td>24</td>
<td>31</td>
<td>41</td>
<td>25</td>
<td>9</td>
<td>2.72 (1.17)</td>
<td>130</td>
</tr>
<tr>
<td>Cognitive Restructuring</td>
<td>13</td>
<td>27</td>
<td>42</td>
<td>34</td>
<td>13</td>
<td>3.05 (1.13)</td>
<td>129</td>
</tr>
<tr>
<td>Problem-Solving and/or Decision-Making Skills Training</td>
<td>2</td>
<td>12</td>
<td>21</td>
<td>56</td>
<td>53</td>
<td>4.01 (.99)</td>
<td>144</td>
</tr>
<tr>
<td>Experiential Avoidance Prevention</td>
<td>36</td>
<td>29</td>
<td>28</td>
<td>27</td>
<td>7</td>
<td>2.53 (1.26)</td>
<td>127</td>
</tr>
<tr>
<td>Emotion Regulation Skills Training</td>
<td>13</td>
<td>18</td>
<td>42</td>
<td>42</td>
<td>19</td>
<td>3.27 (1.16)</td>
<td>134</td>
</tr>
<tr>
<td>Exposure and Response Prevention</td>
<td>36</td>
<td>34</td>
<td>32</td>
<td>15</td>
<td>3</td>
<td>2.29 (1.10)</td>
<td>120</td>
</tr>
<tr>
<td>Behavioral Rehearsal/Role-Play</td>
<td>19</td>
<td>36</td>
<td>33</td>
<td>21</td>
<td>22</td>
<td>2.93 (1.30)</td>
<td>131</td>
</tr>
<tr>
<td>Relaxation and/or Breathing Training</td>
<td>23</td>
<td>31</td>
<td>34</td>
<td>27</td>
<td>9</td>
<td>2.74 (1.20)</td>
<td>124</td>
</tr>
<tr>
<td>Socratic Questioning</td>
<td>28</td>
<td>24</td>
<td>31</td>
<td>35</td>
<td>18</td>
<td>2.93 (1.34)</td>
<td>136</td>
</tr>
<tr>
<td>Modeling/Imitation</td>
<td>37</td>
<td>24</td>
<td>25</td>
<td>18</td>
<td>19</td>
<td>2.66 (1.44)</td>
<td>123</td>
</tr>
</tbody>
</table>
A more in-depth exploration of the specific techniques used by service providers during equine-assisted therapy sessions was also conducted. Specifically, participants were given two hypothetical clients (i.e., an adult with depression and a child/adolescent with oppositional or conduct issues) and asked to rate the extent to which they would use techniques commonly found in a broad range of treatment approaches when providing equine therapy to the individual. The techniques provided included both evidence-based and non-evidence-based practices for adults with depression and children/adolescents with oppositional or conduct issues, respectively. The same Likert scale as used previously in the survey question was applied for these questions as well (i.e., 1 = not at all, 2 = to a slight extent, 3 = to a moderate extent, 4 = to a great extent, 5 = to a very great extent). These results are depicted in Table 4 and Table 5, respectively.
Table 4

Extent to Which Various Techniques Are Used by Participants During an Equine Therapy Session With an Adult With Depression

<table>
<thead>
<tr>
<th>Treatment Technique</th>
<th>1 Not at All (n)</th>
<th>2 Slight Extent (n)</th>
<th>3 Moderate Extent (n)</th>
<th>4 Great Extent (n)</th>
<th>5 Very Great Extent (n)</th>
<th>Mean (Standard Deviation)</th>
<th>(N = 121) Total Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive restructuring*</td>
<td>10</td>
<td>18</td>
<td>29</td>
<td>37</td>
<td>10</td>
<td>3.18 (1.13)</td>
<td>104</td>
</tr>
<tr>
<td>Behavioral activation strategies*</td>
<td>11</td>
<td>23</td>
<td>32</td>
<td>22</td>
<td>9</td>
<td>2.95 (1.14)</td>
<td>97</td>
</tr>
<tr>
<td>Activity and pleasant events scheduling*</td>
<td>19</td>
<td>18</td>
<td>32</td>
<td>27</td>
<td>10</td>
<td>2.92 (1.24)</td>
<td>106</td>
</tr>
<tr>
<td>Mindfulness exercises*</td>
<td>4</td>
<td>17</td>
<td>29</td>
<td>29</td>
<td>34</td>
<td>3.64 (1.17)</td>
<td>113</td>
</tr>
<tr>
<td>Empty-chair exercises</td>
<td>62</td>
<td>24</td>
<td>9</td>
<td>4</td>
<td>1</td>
<td>1.58 (.89)</td>
<td>100</td>
</tr>
<tr>
<td>Therapeutic metaphors</td>
<td>6</td>
<td>2</td>
<td>16</td>
<td>37</td>
<td>54</td>
<td>4.14 (1.07)</td>
<td>115</td>
</tr>
<tr>
<td>Assignment of homework*</td>
<td>16</td>
<td>38</td>
<td>30</td>
<td>16</td>
<td>5</td>
<td>2.58 (1.07)</td>
<td>105</td>
</tr>
<tr>
<td>Relaxation exercises*</td>
<td>12</td>
<td>26</td>
<td>29</td>
<td>25</td>
<td>16</td>
<td>3.06 (1.23)</td>
<td>108</td>
</tr>
<tr>
<td>Encourage client to try new behaviors*</td>
<td>2</td>
<td>10</td>
<td>19</td>
<td>47</td>
<td>32</td>
<td>3.88 (.99)</td>
<td>110</td>
</tr>
<tr>
<td>Maintain a strong focus on therapist-client relationship*</td>
<td>13</td>
<td>24</td>
<td>30</td>
<td>21</td>
<td>16</td>
<td>3.03 (1.25)</td>
<td>104</td>
</tr>
<tr>
<td>Attempt to identify the cause of the depressive symptoms</td>
<td>16</td>
<td>25</td>
<td>31</td>
<td>24</td>
<td>12</td>
<td>2.92 (1.22)</td>
<td>108</td>
</tr>
<tr>
<td>Focus on mastering the client’s awareness</td>
<td>5</td>
<td>10</td>
<td>26</td>
<td>35</td>
<td>32</td>
<td>3.73 (1.12)</td>
<td>108</td>
</tr>
<tr>
<td>Treatment Technique</td>
<td>1 Not at All (n)</td>
<td>2 Slight Extent (n)</td>
<td>3 Moderate Extent (n)</td>
<td>4 Great Extent (n)</td>
<td>5 Very Great Extent (n)</td>
<td>Mean (Standard Deviation)</td>
<td>(N = 121) Total Frequency</td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------</td>
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<td>---------------------</td>
<td>------------------</td>
<td>------------------------</td>
<td>---------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Discussion of the interrelationship between thoughts, feelings, and behaviors*</td>
<td>4</td>
<td>13</td>
<td>29</td>
<td>28</td>
<td>36</td>
<td>3.72 (1.15)</td>
<td>110</td>
</tr>
<tr>
<td>Encourage client not to allow negative rewards to dictate their behavior*</td>
<td>25</td>
<td>25</td>
<td>24</td>
<td>18</td>
<td>12</td>
<td>2.68 (1.32)</td>
<td>104</td>
</tr>
<tr>
<td>Have client distinguish between their thoughts and feelings*</td>
<td>11</td>
<td>18</td>
<td>24</td>
<td>27</td>
<td>26</td>
<td>3.37 (1.30)</td>
<td>106</td>
</tr>
<tr>
<td>Learn about client’s thoughts that seem to occur automatically*</td>
<td>10</td>
<td>16</td>
<td>32</td>
<td>27</td>
<td>19</td>
<td>3.28 (1.21)</td>
<td>104</td>
</tr>
<tr>
<td>Evaluate whether client’s automatic thoughts are accurate or perhaps biased*</td>
<td>16</td>
<td>13</td>
<td>32</td>
<td>26</td>
<td>19</td>
<td>3.18 (1.29)</td>
<td>106</td>
</tr>
<tr>
<td>Help client develop skills to notice, interpret, and correct biased thoughts*</td>
<td>8</td>
<td>12</td>
<td>31</td>
<td>33</td>
<td>27</td>
<td>3.53 (1.18)</td>
<td>111</td>
</tr>
<tr>
<td>Focus on early learning experiences that may be related to depression</td>
<td>23</td>
<td>31</td>
<td>27</td>
<td>13</td>
<td>12</td>
<td>2.62 (1.27)</td>
<td>106</td>
</tr>
<tr>
<td>Treatment Technique</td>
<td>1 Not at All $(n)$</td>
<td>2 Slight Extent $(n)$</td>
<td>3 Moderate Extent $(n)$</td>
<td>4 Great Extent $(n)$</td>
<td>5 Very Great Extent $(n)$</td>
<td>Mean (Standard Deviation)</td>
<td>$(N = 121)$ Total Frequency</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
<td>--------------------</td>
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<td>------------------------</td>
<td>---------------------</td>
<td>--------------------------</td>
<td>--------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Focus on the factors that are currently maintaining the depressive behaviors*</td>
<td>10</td>
<td>14</td>
<td>34</td>
<td>34</td>
<td>17</td>
<td>3.31 (1.16)</td>
<td>109</td>
</tr>
<tr>
<td>Encourage client to work on accepting and/or tolerating painful emotions*</td>
<td>14</td>
<td>20</td>
<td>33</td>
<td>26</td>
<td>15</td>
<td>3.07 (1.23)</td>
<td>108</td>
</tr>
<tr>
<td>Reflection and clarification of client’s verbal and non-verbal behavior*</td>
<td>2</td>
<td>9</td>
<td>22</td>
<td>34</td>
<td>46</td>
<td>4.0 (1.04)</td>
<td>113</td>
</tr>
<tr>
<td>Focus on self-realization through here-and-now experiments in directed awareness</td>
<td>8</td>
<td>9</td>
<td>24</td>
<td>32</td>
<td>35</td>
<td>3.71 (1.22)</td>
<td>108</td>
</tr>
<tr>
<td>Teach client strategies to promote more effective problem-solving and decision-making*</td>
<td>11</td>
<td>10</td>
<td>23</td>
<td>37</td>
<td>33</td>
<td>3.62 (1.26)</td>
<td>114</td>
</tr>
<tr>
<td>Focus on how some thoughts or behaviors might get “rewarded” within client’s environment*</td>
<td>13</td>
<td>26</td>
<td>31</td>
<td>21</td>
<td>14</td>
<td>2.97 (1.22)</td>
<td>105</td>
</tr>
<tr>
<td>Treatment Technique</td>
<td>1 Not at All (n)</td>
<td>2 Slight Extent (n)</td>
<td>3 Moderate Extent (n)</td>
<td>4 Great Extent (n)</td>
<td>5 Very Great Extent (n)</td>
<td>Mean (Standard Deviation)</td>
<td>(N = 121) Total Frequency</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>------------------</td>
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<td>----------------------</td>
<td>-------------------</td>
<td>-------------------------</td>
<td>---------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Focus on childhood and previous life experiences that may be impacting or maintaining depressive behaviors</td>
<td>25</td>
<td>34</td>
<td>24</td>
<td>12</td>
<td>12</td>
<td>2.55 (1.28)</td>
<td>107</td>
</tr>
<tr>
<td>Encourage client to engage in activities that promote a sense of pleasure or mastery inside and outside of sessions*</td>
<td>2</td>
<td>22</td>
<td>23</td>
<td>30</td>
<td>31</td>
<td>3.61 (1.16)</td>
<td>108</td>
</tr>
<tr>
<td>Help client understand that internal representations of experiences are organized around interpersonal relations</td>
<td>14</td>
<td>27</td>
<td>30</td>
<td>22</td>
<td>9</td>
<td>2.85 (1.17)</td>
<td>102</td>
</tr>
<tr>
<td>Focus on interpretations of transference, defense mechanisms, and current symptoms of depression</td>
<td>24</td>
<td>25</td>
<td>30</td>
<td>17</td>
<td>10</td>
<td>2.66 (1.26)</td>
<td>106</td>
</tr>
<tr>
<td>Help client understand that interpersonal factors may contribute heavily to his/her depressed mood*</td>
<td>13</td>
<td>26</td>
<td>28</td>
<td>26</td>
<td>12</td>
<td>2.98 (1.21)</td>
<td>105</td>
</tr>
</tbody>
</table>
Table 4—Continued

<table>
<thead>
<tr>
<th>Treatment Technique</th>
<th>1 Not at All (n)</th>
<th>2 Slight Extent (n)</th>
<th>3 Moderate Extent (n)</th>
<th>4 Great Extent (n)</th>
<th>5 Very Great Extent (n)</th>
<th>Mean (Standard Deviation)</th>
<th>(N = 121) Total Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help client understand that depression affects people's relationships and these relationships further affect our mood*</td>
<td>11</td>
<td>21</td>
<td>31</td>
<td>28</td>
<td>17</td>
<td>3.18 (1.21)</td>
<td>108</td>
</tr>
<tr>
<td>Have client complete standardized outcome measures to track their progress in treatment or their severity of symptoms*</td>
<td>39</td>
<td>25</td>
<td>26</td>
<td>8</td>
<td>5</td>
<td>2.17 (1.17)</td>
<td>103</td>
</tr>
</tbody>
</table>

*Note. Treatment techniques considered evidence-based practices are denoted by asterisk.

Table 5

Extent to Which Various Techniques Are Used by Participants During an Equine Therapy Session With a Child/Adolescent with Oppositional or Conduct Issues

<table>
<thead>
<tr>
<th>Treatment Technique</th>
<th>1 Not at All (n)</th>
<th>2 Slight Extent (n)</th>
<th>3 Moderate Extent (n)</th>
<th>4 Great Extent (n)</th>
<th>5 Very Great Extent (n)</th>
<th>Mean (Standard Deviation)</th>
<th>(N = 118) Total Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modeling/Imitation of appropriate behaviors*</td>
<td>4</td>
<td>17</td>
<td>25</td>
<td>38</td>
<td>27</td>
<td>3.6 (1.12)</td>
<td>111</td>
</tr>
<tr>
<td>Behavioral rehearsal of appropriate behaviors*</td>
<td>7</td>
<td>19</td>
<td>25</td>
<td>41</td>
<td>16</td>
<td>3.37 (1.13)</td>
<td>108</td>
</tr>
</tbody>
</table>
Table 5—Continued

<table>
<thead>
<tr>
<th>Treatment Technique</th>
<th>1 Not at All (n)</th>
<th>2 Slight Extent (n)</th>
<th>3 Moderate Extent (n)</th>
<th>4 Great Extent (n)</th>
<th>5 Very Great Extent (n)</th>
<th>Mean (Standard Deviation)</th>
<th>(N = 118) Total Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involvement of the child’s parents in the treatment process*</td>
<td>3</td>
<td>12</td>
<td>28</td>
<td>39</td>
<td>32</td>
<td>3.75 (1.06)</td>
<td>114</td>
</tr>
<tr>
<td>Social skills training*</td>
<td>2</td>
<td>10</td>
<td>21</td>
<td>48</td>
<td>31</td>
<td>3.86 (.99)</td>
<td>112</td>
</tr>
<tr>
<td>Anger management techniques*</td>
<td>2</td>
<td>6</td>
<td>19</td>
<td>51</td>
<td>34</td>
<td>3.97 (.92)</td>
<td>112</td>
</tr>
<tr>
<td>Focus on improving interpersonal skills*</td>
<td>0</td>
<td>4</td>
<td>19</td>
<td>50</td>
<td>40</td>
<td>4.12 (.81)</td>
<td>113</td>
</tr>
<tr>
<td>Play therapy strategies (free-range play)</td>
<td>10</td>
<td>18</td>
<td>24</td>
<td>33</td>
<td>22</td>
<td>3.36 (1.25)</td>
<td>107</td>
</tr>
<tr>
<td>Rewarding or praising desirable/positive behaviors*</td>
<td>7</td>
<td>18</td>
<td>24</td>
<td>30</td>
<td>31</td>
<td>3.55 (1.24)</td>
<td>110</td>
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<tr>
<td>Shaping of more appropriate behaviors*</td>
<td>3</td>
<td>10</td>
<td>29</td>
<td>41</td>
<td>26</td>
<td>3.71 (1.02)</td>
<td>109</td>
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<tr>
<td>Assignment of homework*</td>
<td>16</td>
<td>44</td>
<td>27</td>
<td>17</td>
<td>3</td>
<td>2.5 (1.02)</td>
<td>107</td>
</tr>
<tr>
<td>Place emphasis on client’s strengths*</td>
<td>0</td>
<td>4</td>
<td>15</td>
<td>41</td>
<td>48</td>
<td>4.23 (.83)</td>
<td>108</td>
</tr>
<tr>
<td>Focus on current thoughts, feelings, and behaviors*</td>
<td>1</td>
<td>7</td>
<td>17</td>
<td>51</td>
<td>36</td>
<td>4.02 (.90)</td>
<td>112</td>
</tr>
<tr>
<td>Engage in role-play exercises*</td>
<td>10</td>
<td>27</td>
<td>24</td>
<td>33</td>
<td>13</td>
<td>3.11 (1.19)</td>
<td>107</td>
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<tr>
<td>Ignore or punish deviant/negative behaviors*</td>
<td>24</td>
<td>48</td>
<td>19</td>
<td>8</td>
<td>5</td>
<td>2.25 (1.05)</td>
<td>104</td>
</tr>
<tr>
<td>Address child’s social-cognitive distortions*</td>
<td>7</td>
<td>22</td>
<td>28</td>
<td>34</td>
<td>13</td>
<td>3.23 (1.13)</td>
<td>104</td>
</tr>
</tbody>
</table>
Table 5—Continued

<table>
<thead>
<tr>
<th>Treatment Technique</th>
<th>1 Not at All (n)</th>
<th>2 Slight Extent (n)</th>
<th>3 Moderate Extent (n)</th>
<th>4 Great Extent (n)</th>
<th>5 Very Great Extent (n)</th>
<th>Mean (Standard Deviation)</th>
<th>(N = 118) Total Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem-solving skills training*</td>
<td>2</td>
<td>5</td>
<td>26</td>
<td>48</td>
<td>34</td>
<td>3.93 (.92)</td>
<td>115</td>
</tr>
<tr>
<td>Perspective-taking skills training*</td>
<td>10</td>
<td>13</td>
<td>29</td>
<td>37</td>
<td>16</td>
<td>3.34 (1.17)</td>
<td>105</td>
</tr>
<tr>
<td>Relaxation exercises (PMR, deep breathing, circular breathing, etc.)*</td>
<td>16</td>
<td>11</td>
<td>27</td>
<td>32</td>
<td>18</td>
<td>3.24 (1.30)</td>
<td>104</td>
</tr>
<tr>
<td>Imposing consequences for compliant and non-compliant in-session behavior*</td>
<td>25</td>
<td>30</td>
<td>28</td>
<td>16</td>
<td>6</td>
<td>2.5 (1.18)</td>
<td>105</td>
</tr>
<tr>
<td>Increase child’s methods of effectively dealing with his/her thoughts and feelings*</td>
<td>2</td>
<td>7</td>
<td>25</td>
<td>44</td>
<td>33</td>
<td>3.89 (.97)</td>
<td>111</td>
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<tr>
<td>Encourage client to use self-statements to inhibit impulsive, problematic behavior*</td>
<td>9</td>
<td>16</td>
<td>24</td>
<td>43</td>
<td>15</td>
<td>3.36 (1.15)</td>
<td>107</td>
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<tr>
<td>Help child to gain greater self-awareness and understanding about his/her own actions</td>
<td>0</td>
<td>6</td>
<td>21</td>
<td>39</td>
<td>49</td>
<td>4.14 (.90)</td>
<td>115</td>
</tr>
</tbody>
</table>
Table 5—Continued

<table>
<thead>
<tr>
<th>Treatment Technique</th>
<th>1 Not at All (n)</th>
<th>2 Slight Extent (n)</th>
<th>3 Moderate Extent (n)</th>
<th>4 Great Extent (n)</th>
<th>5 Very Great Extent (n)</th>
<th>Mean (Standard Deviation)</th>
<th>(N = 118) Total Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attempt to determine how problematic thoughts or behaviors may accidentally get “rewarded” within a young person’s environment*</td>
<td>12</td>
<td>15</td>
<td>32</td>
<td>32</td>
<td>13</td>
<td>3.18 (1.18)</td>
<td>104</td>
</tr>
<tr>
<td>Work to increase the strength of the emotional ties between the child and his/her parents*</td>
<td>6</td>
<td>10</td>
<td>39</td>
<td>26</td>
<td>27</td>
<td>3.54 (1.13)</td>
<td>108</td>
</tr>
<tr>
<td>Allow the child to talk openly about his/her feelings in order to gain new insights and perspectives</td>
<td>0</td>
<td>5</td>
<td>20</td>
<td>31</td>
<td>58</td>
<td>4.25 (.90)</td>
<td>114</td>
</tr>
<tr>
<td>Work with child to pinpoint emotions/feelings that may be maintaining or worsening their problem behavior*</td>
<td>1</td>
<td>10</td>
<td>19</td>
<td>38</td>
<td>39</td>
<td>3.97 (1.00)</td>
<td>107</td>
</tr>
<tr>
<td>Just allow the client to engage with the horses in any manner desired (i.e., free time with the horses)</td>
<td>10</td>
<td>22</td>
<td>34</td>
<td>29</td>
<td>21</td>
<td>3.25 (1.21)</td>
<td>116</td>
</tr>
</tbody>
</table>

*Note. Treatment techniques considered evidence-based practices are denoted by asterisk.
Based on resulting mean scores, this analysis suggested participants were most likely to implement the following techniques when providing equine-assisted therapy to an adult client with depression: therapeutic metaphors, reflection and clarification of client’s verbal and nonverbal behavior, encouraging the client to try new behaviors, focusing on mastering the client’s awareness, discussion of the interrelationship of thoughts, feelings, and behaviors, and focusing on self-realization through here-and-now experiments in directed awareness. When working with children or adolescents with oppositional or conduct issues, the most commonly applied techniques were as follows: allowing the child to talk openly about his or her feelings in order to gain new insights and perspectives, placing emphasis on client’s strengths, helping the child to gain greater self-awareness and understanding about his or her own actions, focusing on improving interpersonal skills, and focusing on current thoughts, feelings, and behaviors.

For further analyses, participants who selected Cognitive, Behavioral, or Cognitive Behavioral theories as the foremost orientation that guides their practice were compared with participants of all other orientations on their likelihood of using evidence-based practices when providing equine-assisted therapy to an adult with depression or a child/adolescent with oppositional or conduct issues. Independent-samples t-tests were conducted to compare the two groups. Results indicated no significant difference in scores for participants with Cognitive, Behavioral, or Cognitive Behavioral orientations ($M = 2.91$, $SD = .80$) and participants of all other orientations.
(M = 2.95, SD = .71; t(122) = .24, p = .81) on their use of evidence-based practices when working with an adult with depression. The magnitude of differences in the means was very small (eta squared = .0005). There were also no significant differences in scores for participants with Cognitive, Behavioral, or Cognitive Behavioral orientations (M = 2.57, SD = .81) and participants of all other orientations (M = 2.75, SD = .76; t(115) = 1.08, p = .28) on their use of non-evidence-based practices when working with an adult with depression. The magnitude of differences in the means was very small (eta squared = .01).

Results indicated a statistically significant difference between scores for participants with Cognitive, Behavioral, or Cognitive Behavioral orientations (M = 3.70, SD = .69) and participants of all other orientations (M = 3.42, SD = .69; t(115) = −2.04, p = .04) on their use of evidence-based practices when working with a child/adolescent with conduct or oppositional issues. The magnitude of differences in the means was small (eta squared = .03). There was also a significant difference in scores for participants with Cognitive, Behavioral, or Cognitive Behavioral orientations (M = 4.05, SD = .65) and participants of all other orientations (M = 3.63, SD = .63; t(115 ) = −2.96, p = .004) on their use of non-evidence-based practices when working with a child/adolescent with conduct or oppositional issues. The magnitude of differences in the means was moderate (eta squared = .07).

An additional area of interest for this study was to assess participants’ feelings and beliefs about using new types of therapy, interventions, or treatment, including
those considered “manualized.” To this end, the web-based survey featured questions from the Evidence-Based Practice Attitude Scale (EBPAS) (Aarons, 2004), which was designed to measure mental health service providers’ attitudes about adopting new or different therapies or interventions. Table 6 includes the questions and results from participants’ responses to the EBPAS items 1-8.

Table 6

Extent to Which Participants Agree With Statements Regarding Their Use of New Interventions

<table>
<thead>
<tr>
<th>EPBAS Question</th>
<th>1 Not at All (n)</th>
<th>2 Slight Extent (n)</th>
<th>3 Moderate Extent (n)</th>
<th>4 Great Extent (n)</th>
<th>5 Very Great Extent (n)</th>
<th>Mean (Standard Deviation)</th>
<th>(N = 126) Total Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>I like to use new types of therapy/intervention to help my clients.</td>
<td>2</td>
<td>13</td>
<td>52</td>
<td>41</td>
<td>15</td>
<td>3.44 (.90)</td>
<td>123</td>
</tr>
<tr>
<td>I am willing to try new types of therapy/intervention even if I have to follow a treatment manual.</td>
<td>4</td>
<td>26</td>
<td>47</td>
<td>35</td>
<td>10</td>
<td>3.17 (.97)</td>
<td>122</td>
</tr>
<tr>
<td>I know better than academic researchers how to care for my clients.</td>
<td>36</td>
<td>45</td>
<td>24</td>
<td>8</td>
<td>2</td>
<td>2.09 (.98)</td>
<td>115</td>
</tr>
<tr>
<td>I am willing to use new and different types of therapy/intervention developed by researchers.</td>
<td>1</td>
<td>16</td>
<td>54</td>
<td>36</td>
<td>15</td>
<td>3.39 (.90)</td>
<td>122</td>
</tr>
</tbody>
</table>
Table 6—Continued

<table>
<thead>
<tr>
<th>EPBAS Question</th>
<th>1 Not at All (n)</th>
<th>2 Slight Extent (n)</th>
<th>3 Moderate Extent (n)</th>
<th>4 Great Extent (n)</th>
<th>5 Very Great Extent (n)</th>
<th>Mean (Standard Deviation)</th>
<th>(N = 126) Total Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research based treatments/ interventions are not clinically useful.</td>
<td>69</td>
<td>27</td>
<td>17</td>
<td>1</td>
<td>0</td>
<td>1.56 (.78)</td>
<td>114</td>
</tr>
<tr>
<td>Clinical experience is more important than using manualized therapy/intervention</td>
<td>11</td>
<td>34</td>
<td>42</td>
<td>22</td>
<td>10</td>
<td>2.88 (1.08)</td>
<td>119</td>
</tr>
<tr>
<td>I would not use manualized therapy/intervention</td>
<td>62</td>
<td>31</td>
<td>19</td>
<td>4</td>
<td>0</td>
<td>1.70 (.87)</td>
<td>116</td>
</tr>
<tr>
<td>I would try a new therapy/intervention even if it were very different from what I am used to doing.</td>
<td>3</td>
<td>30</td>
<td>46</td>
<td>28</td>
<td>14</td>
<td>3.17 (1.01)</td>
<td>121</td>
</tr>
</tbody>
</table>

Table 7 includes participants’ responses for items 9-15 that are based on the question, “If you received training in a therapy or intervention that was new to you, how likely would you be to adopt it if ...”
Table 7

*Extent to Which Participants Would Adopt a New Intervention They Received Training in Providing . . .*

<table>
<thead>
<tr>
<th>Provided Circumstances</th>
<th>1 Not at All (n)</th>
<th>2 Slight Extent (n)</th>
<th>3 Moderate Extent (n)</th>
<th>4 Great Extent (n)</th>
<th>5 Very Great Extent (n)</th>
<th>Mean (Standard Deviation)</th>
<th>(N = 133) Total Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>It was intuitively appealing?</td>
<td>0</td>
<td>4</td>
<td>35</td>
<td>54</td>
<td>38</td>
<td>3.96 (.83)</td>
<td>131</td>
</tr>
<tr>
<td>It “made sense” to you?</td>
<td>0</td>
<td>2</td>
<td>22</td>
<td>59</td>
<td>50</td>
<td>4.18 (.76)</td>
<td>133</td>
</tr>
<tr>
<td>It was required by your supervisor?</td>
<td>17</td>
<td>24</td>
<td>32</td>
<td>35</td>
<td>11</td>
<td>2.99 (1.20)</td>
<td>119</td>
</tr>
<tr>
<td>It was required by your agency?</td>
<td>16</td>
<td>24</td>
<td>35</td>
<td>31</td>
<td>13</td>
<td>3.01 (1.20)</td>
<td>119</td>
</tr>
<tr>
<td>It was required by your state?</td>
<td>10</td>
<td>19</td>
<td>39</td>
<td>36</td>
<td>18</td>
<td>3.27 (1.14)</td>
<td>122</td>
</tr>
<tr>
<td>It was being used by colleagues who were happy with it?</td>
<td>0</td>
<td>14</td>
<td>51</td>
<td>51</td>
<td>12</td>
<td>3.48 (.81)</td>
<td>128</td>
</tr>
<tr>
<td>You felt you had enough training to use it correctly?</td>
<td>0</td>
<td>3</td>
<td>19</td>
<td>66</td>
<td>41</td>
<td>4.12 (.74)</td>
<td>129</td>
</tr>
</tbody>
</table>

With the aim of exploring participants’ beliefs about the nature of equine-assisted therapy interventions in general, survey respondents were queried about aspects of the client change process, treatment benefits, challenges to treatment, and the importance of using horses in therapy. Participants were asked to select up to three factors they believe best explain how clients make changes during equine therapy. Table 8 displays results for the closed-ended choices offered for this question and Figure 1 shows open-ended responses suggested by participants via the “other” category.
Table 8

Factors Responsible for Client’s Change Process in Equine-Assisted Therapy According to Participants

<table>
<thead>
<tr>
<th>Factors</th>
<th>Percentages</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of therapeutic metaphors</td>
<td>55.5%</td>
<td>71</td>
</tr>
<tr>
<td>Opportunity for anthropomorphism (i.e., attributing human characteristics or reasoning skills to animals) and/or personification (i.e., giving human traits to non-living objects)</td>
<td>28.1%</td>
<td>36</td>
</tr>
<tr>
<td>The real or perceived risk of interacting with horses</td>
<td>3.1%</td>
<td>4</td>
</tr>
<tr>
<td>The novelty of working closely with horses</td>
<td>11.7%</td>
<td>15</td>
</tr>
<tr>
<td>The ability to actively engage in hands-on activities and experiences that relate to clients' real life, rather than just talking about their experiences abstractly</td>
<td>74.2%</td>
<td>95</td>
</tr>
<tr>
<td>The creation of stressful and challenging situations, made possible through activities with horses, allows clients to navigate their skills and abilities in a “safe” therapeutic setting</td>
<td>35.9%</td>
<td>46</td>
</tr>
<tr>
<td>Results from in-session activities provide immediate feedback (positive and negative) to clients, which help them to understand the consequences of their actions</td>
<td>50.0%</td>
<td>64</td>
</tr>
<tr>
<td>The solution-oriented focus on clients’ strengths as opposed to focus on their problems and weaknesses.</td>
<td>35.9%</td>
<td>46</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>14.1%</td>
<td>18</td>
</tr>
</tbody>
</table>
**“Other” Participant Responses**

Clients feel accepted and often loved by the horses, they feel better about themselves. There is a gain in confidence after being able to do things with the horse such as have the horse follow them around the obstacle course with no lead rope and they maintain this new confidence in the outside world. I have seen clients gain enormous insight into their issues simply by pouring their hearts out to the horse (out of earshot of the mental health team) and then listening for “any wisdom the horse has to offer.

Seeing their behavior patterns repeated in equine activities allows my clients to move from denial to acceptance and change.

**Authentic connection with the horse. Certainly not just a 'novelty.'**

The attachment system repair that occurs when working with horses.

Unique opportunity to learn from and, to interact with horses, who like us, need to belong, need to feel useful and need to feel safe. Horses provide a lifeline back to what is basic and important, what nature wants from us. Horses can be a metaphor, but first it behooves all of us to truly understand these creatures and learn to use our gifts to read horses as well as people correctly. Simple “using” them as a metaphor cheapens their potential and cuts off our clients from a far more enriching experience and connection.

Client human/animal bond develops creating a healthy relationship not often experienced by human to human relationship.

Most important: the actual interaction with another living being to learn interpersonal skills such as empathy, taking another's perspective, intimacy, touch, managing arousal, resilience, etc. Developing RELATIONSHIP that's healthy and real.

**Mind body healing techniques.**

The limbic resonance that occurs in the horse/human relationship that allows a client to experience the non-judgment and unconditional positive regard of the animal is healing in and of itself.

The development of a strong bond with the horse they work with.

**Relationship with the horses.**

I know you said to only pick 3 but I think all of these are great ways to explain the benefits of EAP and other experiential therapies. There isn't one best over the other, it just depends on what the client takes out of it and each may take 3 different ones out of each session.

The interaction they have with the horse will replicate their human relationships and allow them to better understand how they interact with and affect others.

The horse himself as the agent of change, resulting from the relationship.

The visual information. For clients that are visual, they actually are able to see the behavior in action and the response to it.

**Accessing the body/mind through sensory motor input.**

Increased insights in a present time experience and being safe to feel what they are feeling in honest interactions.

---

**Figure 1.** Additional factors thought to be responsible for client change process in equine-assisted therapy.
Next, survey responders were asked to indicate in a broad sense, what they think are the most important client benefits of equine therapy. Closed-ended choices and an option to provide free-form responses via the “other” category were offered. A five-level Likert scale (ranging from no importance to very great importance) was employed for this question. Results indicated that the three benefits most frequently selected as having “very great importance” to clients were an increase in self-confidence ($n = 72, 56.7\%$), an increased sense of empowerment and heightened self-esteem and or self-efficacy ($n = 67, 52.8\%$), and improved quality of life ($n = 55, 44.7\%$). Table 9 and Figure 2 show results for closed and open-ended responses, respectively.

Table 9

*Most Important Client Benefits of Equine Therapy According to Participants*

<table>
<thead>
<tr>
<th>Choices Provided</th>
<th>1 No Importance ($n$)</th>
<th>2 Slight Importance ($n$)</th>
<th>3 Moderate Importance ($n$)</th>
<th>4 Great Importance ($n$)</th>
<th>5 Very Great Importance ($n$)</th>
<th>Mean (SD)</th>
<th>(N = 127) Total $F$</th>
</tr>
</thead>
<tbody>
<tr>
<td>An increase in adaptive skills</td>
<td>0</td>
<td>6</td>
<td>34</td>
<td>65</td>
<td>20</td>
<td>3.79 (.77)</td>
<td>125</td>
</tr>
<tr>
<td>An increased sense of empowerment and heightened self-esteem/self-efficacy</td>
<td>1</td>
<td>1</td>
<td>8</td>
<td>50</td>
<td>67</td>
<td>4.43 (.72)</td>
<td>127</td>
</tr>
<tr>
<td>Decreased negative/maladaptive behaviors</td>
<td>0</td>
<td>14</td>
<td>42</td>
<td>43</td>
<td>25</td>
<td>3.64 (.93)</td>
<td>124</td>
</tr>
</tbody>
</table>
Table 9—Continued

<table>
<thead>
<tr>
<th>Choices Provided</th>
<th>1 No Importance (n)</th>
<th>2 Slight Importance (n)</th>
<th>3 Moderate Importance (n)</th>
<th>4 Great Importance (n)</th>
<th>5 Very Great Importance (n)</th>
<th>Mean (SD) (N = 127)</th>
<th>Total F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved communication (verbal and non-verbal)</td>
<td>0</td>
<td>4</td>
<td>17</td>
<td>55</td>
<td>50</td>
<td>4.20 (.80)</td>
<td>126</td>
</tr>
<tr>
<td>Development of more effective coping skills</td>
<td>1</td>
<td>2</td>
<td>12</td>
<td>66</td>
<td>45</td>
<td>4.21 (.74)</td>
<td>126</td>
</tr>
<tr>
<td>Increase in self-confidence</td>
<td>0</td>
<td>2</td>
<td>11</td>
<td>42</td>
<td>72</td>
<td>4.45 (.72)</td>
<td>127</td>
</tr>
<tr>
<td>Increased awareness of strengths and weaknesses</td>
<td>1</td>
<td>6</td>
<td>20</td>
<td>52</td>
<td>46</td>
<td>4.09 (.89)</td>
<td>125</td>
</tr>
<tr>
<td>An increased ability to manage emotions effectively</td>
<td>0</td>
<td>4</td>
<td>21</td>
<td>56</td>
<td>43</td>
<td>4.11 (.80)</td>
<td>124</td>
</tr>
<tr>
<td>An increase in interpersonal effectiveness</td>
<td>0</td>
<td>2</td>
<td>28</td>
<td>51</td>
<td>42</td>
<td>4.08 (.80)</td>
<td>123</td>
</tr>
<tr>
<td>Improved mental health</td>
<td>1</td>
<td>3</td>
<td>16</td>
<td>52</td>
<td>51</td>
<td>4.21 (.82)</td>
<td>123</td>
</tr>
<tr>
<td>Improved quality of life</td>
<td>3</td>
<td>3</td>
<td>13</td>
<td>49</td>
<td>55</td>
<td>4.22 (.91)</td>
<td>123</td>
</tr>
<tr>
<td>Heightened spiritual awareness</td>
<td>8</td>
<td>28</td>
<td>36</td>
<td>26</td>
<td>24</td>
<td>3.25 (1.20)</td>
<td>122</td>
</tr>
<tr>
<td>Education/Psychoed.</td>
<td>5</td>
<td>30</td>
<td>49</td>
<td>26</td>
<td>10</td>
<td>3.05 (.99)</td>
<td>120</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
</tbody>
</table>
“Other” Participant Responses

<table>
<thead>
<tr>
<th>Increase in learning, from the horses’ modeling, how to orient to present moment experience, and regulate intense affect and emotions as they occur.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhanced body awareness, self-centering skills, regulation of stress response, dampening of PTSD hyperarousal symptoms.</td>
</tr>
<tr>
<td>Increase in self-trust - beyond self-confidence. &quot;I can do this, but even if I fail I can still handle.&quot;</td>
</tr>
<tr>
<td>Improved group dynamic.</td>
</tr>
<tr>
<td>Enhances awareness of the preciousness of being alive.</td>
</tr>
<tr>
<td>Self-regulation and relationship.</td>
</tr>
<tr>
<td>Connecting within themselves and improved grounding.</td>
</tr>
</tbody>
</table>

**Figure 2.** Additional important client benefits of equine therapy according to participants.

Challenges to implementing equine therapy services were explored among participants. Nine potential barriers to successfully carrying out treatment and an option for a free-form response were included in this inquiry and respondents were asked to subjectively rate the degree of challenge associated with each item. The results gleaned from 128 participants suggested the top three biggest obstacles to equine therapy implementation were cost of services incurred by the treatment provider \((n = 47, 37.9\%)\), difficulty with insurance reimbursement issues \((n = 43, 35\%)\), and cost of services being prohibitive to clients \((n = 42, 33.9\%)\). Free-form responses included in the “other” category included issues related to inclement weather, lack of effective publicity for this treatment model, confusion within the general community about the difference between equine activities and equine therapy, inability to find qualified equine
specialists, insufficient time for collaboration between mental health professionals and equine specialists, and deficient leadership from professional organizations. Table 10 features a comprehensive summary of responses for this survey item.

Table 10

Challenges to Implementing Equine Therapy Services

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>No Challenge (n)</th>
<th>Slight Challenge (n)</th>
<th>Moderate Challenge (n)</th>
<th>Great Challenge (n)</th>
<th>Very Great Challenge (n)</th>
<th>Mean (SD)</th>
<th>(N = 128) Total F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance reimbursement</td>
<td>11</td>
<td>14</td>
<td>24</td>
<td>31</td>
<td>43</td>
<td>3.66 (1.30)</td>
<td>123</td>
</tr>
<tr>
<td>Lack of referrals from clients who are interested in this type of therapy method</td>
<td>21</td>
<td>22</td>
<td>36</td>
<td>30</td>
<td>12</td>
<td>2.92 (1.24)</td>
<td>121</td>
</tr>
<tr>
<td>Lack of research on effectiveness of equine therapy</td>
<td>12</td>
<td>22</td>
<td>42</td>
<td>26</td>
<td>24</td>
<td>3.22 (1.22)</td>
<td>126</td>
</tr>
<tr>
<td>Lack of support from the mental health community</td>
<td>14</td>
<td>25</td>
<td>40</td>
<td>33</td>
<td>15</td>
<td>3.08 (1.17)</td>
<td>127</td>
</tr>
<tr>
<td>Lack of support for this type of service in your community</td>
<td>22</td>
<td>30</td>
<td>34</td>
<td>24</td>
<td>15</td>
<td>2.84 (1.27)</td>
<td>125</td>
</tr>
<tr>
<td>Cost of services to the client</td>
<td>5</td>
<td>9</td>
<td>27</td>
<td>41</td>
<td>42</td>
<td>3.85 (1.09)</td>
<td>124</td>
</tr>
<tr>
<td>Cost of services to the provider</td>
<td>2</td>
<td>15</td>
<td>22</td>
<td>38</td>
<td>47</td>
<td>3.91 (1.09)</td>
<td>124</td>
</tr>
<tr>
<td>Finding a setting to provide your services within</td>
<td>47</td>
<td>27</td>
<td>20</td>
<td>17</td>
<td>12</td>
<td>2.35 (1.37)</td>
<td>123</td>
</tr>
<tr>
<td>Finding quality, trained staff for your organization</td>
<td>38</td>
<td>27</td>
<td>24</td>
<td>21</td>
<td>12</td>
<td>2.52 (1.35)</td>
<td>122</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>11</td>
</tr>
</tbody>
</table>
Understanding the function of the horse within this model of treatment was another important element of the study. With this goal in mind, participants were asked to convey why they believe horses are an important feature of therapy. Seven choices were offered and a free-form response option was also provided. Based on the results, the three most important (i.e., ranked 1st) perceived benefits of horses were their ability to read and sense humans’ feeling and emotions, which they mirror back to clients \((n = 56, 47.5\%)\), the vast opportunity for metaphoric learning they provide \((n = 31, 25.2\%)\), and the fact that they are social animals with many similarities to humans \((n = 14, 12.1\%)\) (see Table 11 for complete results). Themes elicited from the free-form “other” category suggested that horses are non-judgmental, they provide an experiential interaction and relationship, and they engage clients at a somatosensory level, qualities which allow for a dynamic therapeutic experience.

**Table 11**

*Participants Beliefs About Why Horses Are an Important Feature of Therapy*

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>1st Most Important (n)</th>
<th>2nd (n)</th>
<th>3rd (n)</th>
<th>4th (n)</th>
<th>5th (n)</th>
<th>6th (n)</th>
<th>7th Least Important (n)</th>
<th>(N = 127) Total F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Their size introduces feelings of fear, intimidation, discomfort, etc. that can help bring about change for the client</td>
<td>3 (2.6%)</td>
<td>8 (7.0%)</td>
<td>12 (10.5%)</td>
<td>9 (7.9%)</td>
<td>26 (22.8%)</td>
<td>31 (27.2%)</td>
<td>25 (21.9%)</td>
<td>114</td>
</tr>
</tbody>
</table>
### Table 11—Continued

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>1&lt;sup&gt;st&lt;/sup&gt; Most Important (n)</th>
<th>2&lt;sup&gt;nd&lt;/sup&gt; (n)</th>
<th>3&lt;sup&gt;rd&lt;/sup&gt; (n)</th>
<th>4&lt;sup&gt;th&lt;/sup&gt; (n)</th>
<th>5&lt;sup&gt;th&lt;/sup&gt; (n)</th>
<th>6&lt;sup&gt;th&lt;/sup&gt; (n)</th>
<th>7&lt;sup&gt;th&lt;/sup&gt; Least Important (n)</th>
<th>(N = 127) Total F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Horses can read/sense humans’ feelings and emotions, which they mirror back to clients. This process can be helpful in therapy.</td>
<td>56 (47.5%)</td>
<td>22 (18.6%)</td>
<td>17 (14.4%)</td>
<td>11 (9.3%)</td>
<td>7 (5.9%)</td>
<td>3 (2.5%)</td>
<td>2 (1.7%)</td>
<td>118</td>
</tr>
<tr>
<td>Horses are intuitive animals</td>
<td>14 (11.8%)</td>
<td>35 (29.4%)</td>
<td>22 (18.5%)</td>
<td>18 (15.1%)</td>
<td>14 (11.8%)</td>
<td>16 (13.4%)</td>
<td>0 (0%)</td>
<td>119</td>
</tr>
<tr>
<td>Horses are magical creatures</td>
<td>4 (3.5%)</td>
<td>0 (0%)</td>
<td>3 (2.6%)</td>
<td>4 (3.5%)</td>
<td>3 (2.6%)</td>
<td>18 (15.8%)</td>
<td>82 (71.9%)</td>
<td>114</td>
</tr>
<tr>
<td>Horses are large and powerful animals, which helps clients to overcome fear and develop confidence</td>
<td>3 (2.6%)</td>
<td>13 (11.3%)</td>
<td>20 (17.4%)</td>
<td>26 (22.6%)</td>
<td>33 (28.7%)</td>
<td>18 (15.7%)</td>
<td>2 (1.7%)</td>
<td>115</td>
</tr>
<tr>
<td>Horses are social animals with many similarities to humans</td>
<td>14 (12.1%)</td>
<td>21 (18.1%)</td>
<td>31 (26.7%)</td>
<td>20 (17.2%)</td>
<td>14 (12.1%)</td>
<td>15 (12.9%)</td>
<td>1 (0.9%)</td>
<td>116</td>
</tr>
<tr>
<td>Horses provide vast opportunity for metaphoric learning</td>
<td>31 (25.2%)</td>
<td>26 (21.1%)</td>
<td>15 (12.2%)</td>
<td>27 (22.0%)</td>
<td>15 (12.2%)</td>
<td>8 (6.5%)</td>
<td>1 (0.8%)</td>
<td>123</td>
</tr>
</tbody>
</table>
To examine further the relationship between participants’ reported theoretical orientation and their opinions on the function of the horse within therapy, cross tabulations were conducted. Findings indicated that of the fourteen theoretical orientation categories, participants who identified themselves as fitting into all but Eclectic, Rogerian, and Trantheoretical believed that the most important feature of the horse was its ability to read and sense humans’ feelings and emotions, which it seemingly mirrors back to the client. Participants classifying themselves as Eclectic and Rogerian suggested the horse’s ability to provide vast opportunities for metaphorical learning to be its most important quality. Finally, the four participants who identified themselves as Trantheoretical and answered this question, each chose the following as the most important feature of the horse: their size introduces feelings of fear, intimidation, and discomfort that help bring about change for the client; its ability to read and sense humans’ feelings and emotions; its ability to provide vast opportunities for metaphorical learning, and its social nature and similarity to humans. See Table 12 below for the number of participants in each theoretical orientation category who selected various answer choices as the first, second, and third most important benefit of horses in therapy.
Participants were asked whether or not they felt there were populations of people not appropriate for equine therapy. Of the 130 individuals who answered this question, 53 (40.8%) reported they did not believe any particular group would be unsuitable. Seventy-two of the 77 responders who indicated there were populations they felt inappropriate for equine therapy provided further detail, which included a broad range of groups. The most common responses included clients who are actively psychotic with severe and persistent mental illness, such as schizophrenia or dissociative identity disorder (n = 20); clients with some type of cognitive impairment that precludes...
their ability to learn through metaphor, such as those with autism, traumatic brain injury, and severe concrete thinking styles ($n = 13$); clients who are extremely violent, dangerous, or physically aggressive ($n = 11$); clients who have a history of being cruel to animals ($n = 11$); clients with active addictions or who are intoxicated ($n = 7$); clients with any type of physical limitation that may interfere with their safety ($n = 7$); clients who are not open to or interested in working with horses ($n = 5$); young children ($n = 4$); clients with a history of fire-setting ($n = 4$); clients who are extremely antisocial or who have sociopathic traits ($n = 3$); clients who are severely emotionally disturbed ($n = 3$); and clients who are fearful of horses ($n = 3$). In addition, at least one participant described the following clients to be unsuitable for equine therapy: those who are suicidal; heavily medicated; experiencing a manic episode; extremely guarded; severely oppositional, impulsive; or destructive; and those with severe obsessive compulsive disorder.

**Part II**

The second category of questions included in Phase I of the web-based survey pertained to the agency/organization/practice in which participants work as an equine therapy service provider.

Clarification regarding the treatment setting where participants most often provide equine therapy services was obtained. The most commonly reported setting was within an outpatient program ($n = 57, 44.5\%$), followed by services provided within
a residential treatment program or a farm owned by an equine specialist who
 collaborates with a mental health professional (n = 16, 12.5% and n = 16, 12.5%,
 respectively), a school or educational setting (n = 8, 6.3%), and an inpatient therapy
 program (n = 3, 2.3%). One participant indicated he/she operated from a partial hospital
 program and another within a forensic setting (n = 1, .8% and n = 1, .8%, respectively).
 Settings described in the “other” category were privately owned horse facilities that
 offer clinical services, farms rented by mental health professionals or equine specialists,
 and horse facilities owned by mental health professionals.

 Results indicated that several different models of equine therapy were
 commonly offered within the same location, sometimes by the same facilitators who are
 multi-trained. Each setting also employs a variety of staff above and beyond the MHP
 and ES. Table 13 shows a breakdown of various staff at each location where participants
 provide equine therapy.

### Table 13

*Descriptive Statistics Regarding Number of Staff at Various Locations Where Participants Provide Equine Therapy Services*

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Mode</th>
<th>Range</th>
<th>Standard Deviation</th>
<th>(N = 124) Total Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # of Mental Health Professionals</td>
<td>2.07</td>
<td>1</td>
<td>13</td>
<td>2.11</td>
<td>121</td>
</tr>
<tr>
<td>Total # of Equine Specialists</td>
<td>1.93</td>
<td>1</td>
<td>10</td>
<td>1.55</td>
<td>121</td>
</tr>
<tr>
<td>Total # of Support Staff (office staff, barn help)</td>
<td>3.46</td>
<td>0</td>
<td>100</td>
<td>11.27</td>
<td>85</td>
</tr>
<tr>
<td>Total # of Unpaid Workers (interns, students, volunteers)</td>
<td>16.31</td>
<td>0</td>
<td>300</td>
<td>44.57</td>
<td>85</td>
</tr>
<tr>
<td>Total # of “Other” Staff</td>
<td>4.35</td>
<td>0</td>
<td>75</td>
<td>12.78</td>
<td>60</td>
</tr>
</tbody>
</table>
Within these settings, workers have a broad range of educational degrees from bachelor’s level to medical degrees, in fields such as social work, counseling, psychology, and marriage and family therapy. Equine therapy training among staff at these locations also varies. The most commonly reported certification earned was EAGALA Level I and II, followed by other, unspecified non-EAGALA training; PATH International Certification, OK Corral Series training, EAGALA Advanced certification, and lastly, EFMHA Certification (see Table 14).

Table 14

Descriptive Statistics Regarding Type of Equine Therapy Certification Earned by Staff at Location Participants Provide Equine Therapy Services

<table>
<thead>
<tr>
<th>Training Models</th>
<th>Mean</th>
<th>Mode</th>
<th>Range</th>
<th>Standard Deviation</th>
<th>(N = 120) Total Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>EAGALA Level I and II</td>
<td>2.23</td>
<td>2</td>
<td>12</td>
<td>1.67</td>
<td>110</td>
</tr>
<tr>
<td>EAGALA Advanced</td>
<td>.64</td>
<td>0</td>
<td>2</td>
<td>0.67</td>
<td>41</td>
</tr>
<tr>
<td>OK Corral Series</td>
<td>.78</td>
<td>0</td>
<td>5</td>
<td>1.37</td>
<td>35</td>
</tr>
<tr>
<td>EFMHA</td>
<td>.30</td>
<td>0</td>
<td>2</td>
<td>0.61</td>
<td>27</td>
</tr>
<tr>
<td>PATH International</td>
<td>1.32</td>
<td>1</td>
<td>12</td>
<td>2.05</td>
<td>50</td>
</tr>
<tr>
<td>Other, Non-EAGALA Training</td>
<td>1.85</td>
<td>1</td>
<td>16</td>
<td>3.4</td>
<td>54</td>
</tr>
</tbody>
</table>

Understanding who is present during a typical equine-assisted therapy session is another important component examined within this study. Of the 125 participants who responded to this survey item, 72% (n = 90) reported always having an MHP and an ES present during equine-assisted therapy sessions, 12% (n = 15) reported sometimes having an MHP and ES, 1.6% (n = 2) reported only an MHP or ES is present, and 14.4%
(n = 18) have “other” staff present. Among “other” staff were individuals dually certified as ES and MHP, volunteers/assistants, recreational therapists, individuals certified as Level 2 PATH, Certified Equine Gestalt Coaches, Occupational Therapists, and Physical Therapists.

The most commonly found duration for equine therapy sessions was 45-60 minutes for individual therapy (n = 85, 69.1%), 75-90 minutes for group therapy (n = 33, 27.7%), and 45-60 minutes for family therapy (n = 49, 43.4%) (Total N = 126). The typical course of equine therapy within participants’ treatment locations, on average, was shown to be between five to ten sessions for 31.7% of responders (n = 39), 1 to 5 sessions for 22% (n = 27), 10 to 15 sessions for 15.4% (n = 19), 15 to 20 sessions for 11.4% (n = 14), and more than 20 sessions for 12.2% (n = 15).

The number of horses typically included in the arena during an equine therapy session was shown to vary among responders, most often dependent on the size of the treatment group (n = 43, 34.1%). Twenty-two participants (17.5%) reported using three to five horses per session, 21 (16.7%) use exactly three horses, 13 (10.3%) use two horses, 10 (7.9%) use only one horse, four (3.2%) use five or more horses, and one reported using a horse per person in attendance (.8%) (N = 126). Twelve responders provided various other responses to this survey item. Equine-assisted therapy service providers appear to base horse count on factors such as activity type, group size, client(s) treatment goals, safety issues, space available, and herd dynamics. Most participants indicated they use full size horses exclusively during equine therapy
sessions ($n = 62, 49.2$%), while only one reported using miniature horses exclusively. Fifty-one respondents stated they use both minis and full size horses during equine therapy sessions ($n = 51, 40.5$%) and three (2.4%) allow their clients to choose which horse breed they want to work with. Nine participants selected the “other” category, though four of their answers fit the “both” category and two fit the “full sized” category. The remaining three “other” responders reported using ponies (i.e., less than 14.2 hands in height when mature). The majority of survey takers reported that different horses are used with returning clients at their location ($n = 76, 61.3$%) and the remaining 48 (38.7%) use the same horse with clients during each session.

Twenty-six survey takers (20.8%) reported horsemanship skills (e.g., proper grooming, saddling, and caring for a horse) were generally taught within the location where they provide equine-assisted therapy services. Forty-one participants (32.8%) stated that horsemanship skills were not included in equine-assisted therapy and the remaining 58 (46.4%) indicated that horsemanship skills were only taught if they aligned with the client’s specific treatment goals (e.g., teaching about the importance of grooming to a client with poor hygiene).

Participants were asked to report the overall percentage of ground work involved in equine therapy sessions (i.e., clients working on ground with horse, not involved in riding). Of the 126 who responded to this item, 87 (67%)) indicated ground work was exclusively conducted during equine-assisted therapy, 18 (14.3%) indicated ground work occurred 75-100% of the time, 9 (7.1%) indicated ground work occurred
50-75% of the time, 7 (5.6%) indicated ground work occurred 25-50% of the time, and five participants indicated ground work occurred less than 25% of the time during equine-assisted therapy sessions. Of the 39 who reported riding was involved in equine therapy sessions at their location, two (5%) indicated they adhere to the EAGALA-model, which explicitly prohibits all mounted work.

One hundred twenty-three participants (97.6%) suggested they include a processing or debriefing component within equine-assisted therapy sessions at their treatment location. When asked to provide details regarding what their processing or debriefing entailed, responses varied from introspection and reflection on clients’ experience \((n = 23)\), relating in-session learning to clients’ real life \((n = 15)\), discussion about session and activity that typically involves use of metaphor \((n = 12)\), discussion about observations from session \((e.g., \ SPUD’s) \ (n = 11)\), inquiring about what clients learned from their interaction with the horses \((n = 7)\), art therapy \((n = 4)\), journaling \((n = 4)\), verbal and written reports \((n = 2)\), evaluating clients’ progress towards treatment goals \((n = 1)\), review of safety concerns \((n = 1)\). Several participants also indicated facilitators meet prior to or directly following sessions to debrief and process various issues as a treatment team.

Determining how progress data was collected at participants’ equine therapy location was another aim of this study. Of the 118 survey takers who answered this question, 22 (18.6%) stated they did not collect any type of progress data for equine therapy clients. Remaining participants indicated they collect data from various sources
to help track clients’ progress (see Table 15). Within the “other” category, many stated clients’ progress was routinely tracked by equine therapy providers and other mental health professionals involved in the particular client’s treatment.

Table 15

*Sources Providing Equine Therapy Client Progress Data at Participants’ Location*

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Percentage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>We do not collect client progress data</td>
<td>18.6%</td>
<td>22</td>
</tr>
<tr>
<td>Client</td>
<td>74.6%</td>
<td>88</td>
</tr>
<tr>
<td>Parent/Guardian</td>
<td>55.9%</td>
<td>66</td>
</tr>
<tr>
<td>Teacher</td>
<td>25.4%</td>
<td>30</td>
</tr>
<tr>
<td>Caseworker</td>
<td>32.2%</td>
<td>38</td>
</tr>
<tr>
<td>Parole/Probation Officer</td>
<td>22.0%</td>
<td>26</td>
</tr>
<tr>
<td>Courts</td>
<td>16.1%</td>
<td>19</td>
</tr>
<tr>
<td>Department of Child Services</td>
<td>16.1%</td>
<td>19</td>
</tr>
<tr>
<td>Other</td>
<td>22.0%</td>
<td>26</td>
</tr>
</tbody>
</table>

Further inquiry regarding the measures used to track equine-assisted therapy client progress revealed that most often, informal methods (i.e., review of progress notes, subjective questioning of clients, casual feedback from collateral sources, etc.) were used. Some treatment locations reported use of formal, standardized outcome measures mainly involving self-report and sometimes including feedback from collateral sources such as parents, teachers, or other treatment providers. Similarly, when participants were asked which type of assessment measures were used with equine therapy clients at their location (not restricted to progress measures only) 42.9% \((n = 45)\) revealed they do not use any; 22% \((n = 20)\) use objective personality tests,
including rating scales and self-report measures; 3.8% \((n = 4)\) use projective personality tests (i.e., free response measures); 6.7% \((n = 7)\) use some form of achievement, intelligence, or educational test; 26.7% \((n = 28)\) use behavioral tests, including rating scales and self-report measures; and 4.8% \((n = 5)\) use neuropsychological tests. Thirty-eight participants \((36.2\%)\) reported using various other assessment instruments including trauma-based, substance-abuse screeners, and self-developed tools, while others indicated that assessments were conducted by other treatment providers and shared with the equine therapy providers as needed.

Sixty-nine percent \((n = 80)\) of participants indicated that individualized treatment plans were created for every equine therapy client at the location where they operate. Eleven percent \((n = 13)\) stated that individualized treatment plans were not created for every client, and the remaining 20% \((n = 23)\) reported that it depended on the client, his/her referral source, and various other factors as to whether or not a treatment plan was created \((N = 116\) for this question). Of the participants who reportedly create treatment plans for equine therapy clients at least some of the time \((N = 93)\), 72 \((77.4\%)\) indicated they collaborate with equine therapy clients when doing so, while four participants \((4.3\%)\) do not work with clients. The remaining 17 \((18.3\%)\) survey takers base their decision about whether or not to collaborate with clients during the development of their treatment plan on factors such as client age, cognitive and/or verbal abilities, general attitude towards treatment, and opinion of the referral source or treatment team. Table 16 shows the means by which client psychosocial and
background information is collected at locations where participants provide equine therapy services. Results indicated that of the choices provided, the type of information most commonly obtained from clients was their history of trauma, abuse, neglect, or exposure to violence \((n = 93, 84.5\%)\); presenting problem \((n = 92, 83.67\%)\), goals for therapy \((n = 91, 82\%)\), and current symptoms \((n = 90, 81.1\%)\), all gathered via clinical interview.

Table 16

*Method by Which Psychosocial and Background Information Is Collected by Equine Therapy Clients at Participants’ Location*

<table>
<thead>
<tr>
<th>Type of Information</th>
<th>Do Not Collect</th>
<th>Collect By Clinical Interview</th>
<th>Collect Using Pencil &amp; Paper Survey</th>
<th>((N = 111)) Total Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological history</td>
<td>12</td>
<td>84</td>
<td>14</td>
<td>110</td>
</tr>
<tr>
<td>Medical history</td>
<td>13</td>
<td>76</td>
<td>22</td>
<td>111</td>
</tr>
<tr>
<td>Current medications</td>
<td>12</td>
<td>78</td>
<td>20</td>
<td>110</td>
</tr>
<tr>
<td>Diagnoses (current and previous)</td>
<td>12</td>
<td>87</td>
<td>11</td>
<td>110</td>
</tr>
<tr>
<td>Previous treatment history</td>
<td>12</td>
<td>85</td>
<td>13</td>
<td>110</td>
</tr>
<tr>
<td>Experience with horses</td>
<td>25</td>
<td>76</td>
<td>9</td>
<td>110</td>
</tr>
<tr>
<td>Current symptoms</td>
<td>8</td>
<td>90</td>
<td>13</td>
<td>111</td>
</tr>
<tr>
<td>Presenting problem</td>
<td>7</td>
<td>92</td>
<td>11</td>
<td>110</td>
</tr>
<tr>
<td>Goals for therapy</td>
<td>7</td>
<td>91</td>
<td>13</td>
<td>111</td>
</tr>
<tr>
<td>Social/developmental history</td>
<td>15</td>
<td>80</td>
<td>14</td>
<td>109</td>
</tr>
<tr>
<td>Educational background</td>
<td>25</td>
<td>69</td>
<td>12</td>
<td>106</td>
</tr>
<tr>
<td>Employment history</td>
<td>35</td>
<td>58</td>
<td>11</td>
<td>104</td>
</tr>
<tr>
<td>History of trauma, abuse, neglect or exposure to violence</td>
<td>11</td>
<td>93</td>
<td>6</td>
<td>110</td>
</tr>
<tr>
<td>Substance use</td>
<td>10</td>
<td>89</td>
<td>11</td>
<td>110</td>
</tr>
<tr>
<td>Risk for suicide, self-harm, and/or homicide</td>
<td>10</td>
<td>89</td>
<td>10</td>
<td>109</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td>21</td>
</tr>
</tbody>
</table>
To understand better how equine-assisted therapy treatment providers determine the type and duration of services needed for each client, they were asked if a specific assessment protocol was followed at their location. Eighty-six (76.8%) of responders indicated they did not follow a particular assessment protocol and 26 (23.2%) stated they did ($N = 112$).

Survey respondents were asked whether or not they engaged parents, other family members, or caregivers of equine therapy clients in the treatment process at their location, and if so, how they are involved. Of the 119 participants who responded to this question, 101 (84.9%) reported they do engage others in the treatment process and 18 (15.1%) stated they do not. Based on information provided by 99 of the 101 participants who involve family or caregivers in the treatment process, the following information was gleaned: 32 (32.3%) have them complete assessments; 47 (47.5%) have them help establish treatment goals and treatment plans for the client; and 66 (66.7%) actively include them in equine therapy sessions.

To learn more about the content of equine therapy sessions, participants were asked whether or not they follow a manualized treatment for equine therapy services (i.e., any intervention that has specific guidelines and/or components that are outlined in a manual or are to be followed in a structured or predetermined way). Results indicated that 32 (27.6%) participants conduct manualized therapy and 84 (72.4%) do not. Of these 32, 5 (15.2%) responders reported using a self-developed manual, while 21 (63.6%) use a published manual, and the remaining suggested they use both published
and unpublished manuals, including the EAGALA training manual. Further, these 32 participants were asked if staff received training in the manualized curriculum they follow and if fidelity checks were conducted to make sure staff was adhering to the curriculum. Twenty-five (83.3%) answered “yes” regarding staff training while 5 (16.7%) answered “no” (n = 30) and 19 (63.3%) stated that fidelity checks did occur, while 11 (36.7%) reported they were not conducted.

Client demographic information was another area of interest for the current study. With this in mind, participants were asked to provide information on the frequency with which various client groups were served. Specifically, survey takers were requested to estimate what percentage of their equine therapy clients were male and female. The average percentages of all participants who responded to this question (N = 108) were calculated and yielded the following results: 41.84% male and 58.64% female clients. Tables 17 and 18 show how often participants’ locations provide equine therapy services to various age categories in individual and group therapy and populations, respectively.
Table 17

Percentage of Time Clients in Various Age Groups Are Provided Equine Therapy in Individual and Group Sessions at Participants’ Treatment Location

<table>
<thead>
<tr>
<th>Age Groups by Therapy Mode</th>
<th>75-100% of time</th>
<th>50-75% of time</th>
<th>25-50% of time</th>
<th>&lt;25% of time</th>
<th>N/A</th>
<th>Total Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children - Individual Sessions</td>
<td>7</td>
<td>18</td>
<td>15</td>
<td>38</td>
<td>22</td>
<td>100</td>
</tr>
<tr>
<td>Children - Group Sessions</td>
<td>4</td>
<td>4</td>
<td>10</td>
<td>44</td>
<td>32</td>
<td>94</td>
</tr>
<tr>
<td>Adolescents - Individual Sessions</td>
<td>13</td>
<td>15</td>
<td>25</td>
<td>35</td>
<td>14</td>
<td>102</td>
</tr>
<tr>
<td>Adolescents - Group Sessions</td>
<td>11</td>
<td>13</td>
<td>15</td>
<td>39</td>
<td>19</td>
<td>97</td>
</tr>
<tr>
<td>Adults - Individual Sessions</td>
<td>9</td>
<td>15</td>
<td>22</td>
<td>40</td>
<td>14</td>
<td>100</td>
</tr>
<tr>
<td>Adults - Group Sessions</td>
<td>16</td>
<td>6</td>
<td>15</td>
<td>37</td>
<td>22</td>
<td>96</td>
</tr>
</tbody>
</table>

Table 18

Frequency With Which Equine Therapy Is Provided to Various Client Populations at Participants’ Treatment Location

<table>
<thead>
<tr>
<th>Client Populations</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Frequently</th>
<th>(N = 108) Total Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients with eating disorders</td>
<td>19 (19%)</td>
<td>32 (32%)</td>
<td>40 (40%)</td>
<td>6 (6%)</td>
<td>3 (3%)</td>
<td>100</td>
</tr>
<tr>
<td>Clients with ODD/CD/ADHD</td>
<td>4 (3.9%)</td>
<td>10 (9.7%)</td>
<td>27 (26.2%)</td>
<td>37 (35.9%)</td>
<td>25 (24.3%)</td>
<td>103</td>
</tr>
<tr>
<td>Clients with depression</td>
<td>1 (1%)</td>
<td>4 (3.8%)</td>
<td>29 (27.6%)</td>
<td>51 (48.6%)</td>
<td>20 (19%)</td>
<td>105</td>
</tr>
<tr>
<td>Clients with substance abuse issues</td>
<td>14 (13.6%)</td>
<td>16 (15.5%)</td>
<td>38 (36.9%)</td>
<td>15 (14.6%)</td>
<td>20 (19.4%)</td>
<td>103</td>
</tr>
<tr>
<td>Clients with anxiety disorders</td>
<td>1 (1%)</td>
<td>2 (1.9%)</td>
<td>26 (25.2%)</td>
<td>48 (46.6%)</td>
<td>26 (25.2%)</td>
<td>103</td>
</tr>
<tr>
<td>Clients with Autism, Aspergers, or other ASD or MR/DD diagnoses</td>
<td>16 (15.5%)</td>
<td>28 (27.2%)</td>
<td>26 (25.2%)</td>
<td>23 (22.3%)</td>
<td>10 (9.7%)</td>
<td>103</td>
</tr>
</tbody>
</table>
Table 18—Continued

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients with attachment concerns</td>
<td>4 (3.9%)</td>
<td>19 (18.4%)</td>
<td>36 (35%)</td>
<td>27 (26.2%)</td>
<td>17 (16.5%)</td>
</tr>
<tr>
<td>Clients with PTSD or other trauma related issues</td>
<td>2 (1.9%)</td>
<td>6 (5.6%)</td>
<td>24 (22.4%)</td>
<td>44 (41.1%)</td>
<td>31 (29%)</td>
</tr>
<tr>
<td>Clients with personality disorders (Axis II diagnoses)</td>
<td>15 (14.9%)</td>
<td>38 (37.6%)</td>
<td>27 (26.7%)</td>
<td>15 (14.9%)</td>
<td>6 (5.9%)</td>
</tr>
<tr>
<td>Clients with learning difficulties</td>
<td>6 (5.8%)</td>
<td>21 (20.4%)</td>
<td>42 (40.8%)</td>
<td>20 (19.4%)</td>
<td>14 (13.6%)</td>
</tr>
<tr>
<td>Clients who are physically challenged</td>
<td>30 (29.1%)</td>
<td>42 (40.8%)</td>
<td>18 (17.5%)</td>
<td>8 (7.8%)</td>
<td>5 (4.9%)</td>
</tr>
<tr>
<td>Veterans</td>
<td>46 (45.1%)</td>
<td>22 (21.6%)</td>
<td>16 (15.7%)</td>
<td>12 (11.8%)</td>
<td>6 (5.9%)</td>
</tr>
<tr>
<td>At-Risk Youth</td>
<td>14 (13.7%)</td>
<td>11 (10.8%)</td>
<td>25 (24.5%)</td>
<td>21 (20.6%)</td>
<td>31 (30.4%)</td>
</tr>
<tr>
<td>Forensic/Court Referred</td>
<td>38 (38.4%)</td>
<td>26 (26.3%)</td>
<td>19 (19.2%)</td>
<td>8 (8.1%)</td>
<td>8 (8.1%)</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9</td>
</tr>
</tbody>
</table>

A final area of inquiry within the web-based survey focused on how equine therapy services were funded and who the most common referral sources were. Results suggested that equine-assisted therapy services were funded in various ways across participants’ treatment locations, with the largest percentage of clients being self-pay, private insurance, or other third party sources. Table 19 shows a complete breakdown of funding sources. In terms of referrals for equine-assisted therapy, the largest source indicated by participants was self-advertisement and marketing (n = 33, 36.7%),
followed by other mental health professionals \( n = 33, 33\% \). Table 20 shows a summary of responses for this survey item.

**Table 19**

*Percentage of Clients Funded by Various Sources at Participants’ Treatment Location*

<table>
<thead>
<tr>
<th>Funding Sources</th>
<th>75-100%</th>
<th>50-75%</th>
<th>25-50%</th>
<th>&lt;25%</th>
<th>0%</th>
<th>( (N = 108) ) Total F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Insurance</td>
<td>10 (10.5%)</td>
<td>15 (15.8%)</td>
<td>9 (9.5%)</td>
<td>29 (30.5%)</td>
<td>32 (33.7%)</td>
<td>95</td>
</tr>
<tr>
<td>Public Aid (Medicaid/Medicare)</td>
<td>9 (10.7%)</td>
<td>3 (3.6%)</td>
<td>11 (13.1%)</td>
<td>14 (16.7%)</td>
<td>47 (56%)</td>
<td>84</td>
</tr>
<tr>
<td>Veterans Benefits</td>
<td>0 (0%)</td>
<td>2 (2.6%)</td>
<td>6 (7.8%)</td>
<td>11 (14.3%)</td>
<td>58 (75.3%)</td>
<td>77</td>
</tr>
<tr>
<td>Self-Pay</td>
<td>36 (36%)</td>
<td>16 (16%)</td>
<td>15 (15%)</td>
<td>21 (21%)</td>
<td>12 (12%)</td>
<td>100</td>
</tr>
<tr>
<td>Grant-Funded</td>
<td>7 (9%)</td>
<td>9 (11.5%)</td>
<td>9 (11.5%)</td>
<td>15 (19.2%)</td>
<td>38 (48.7%)</td>
<td>78</td>
</tr>
<tr>
<td>Other public (3rd party) funding</td>
<td>11 (13.1%)</td>
<td>7 (8.3%)</td>
<td>8 (9.5%)</td>
<td>18 (21.4%)</td>
<td>40 (47.6%)</td>
<td>84</td>
</tr>
<tr>
<td>Donations from community</td>
<td>6 (7.5%)</td>
<td>7 (8.8%)</td>
<td>9 (11.3%)</td>
<td>14 (17.5%)</td>
<td>44 (55%)</td>
<td>80</td>
</tr>
<tr>
<td>Other</td>
<td>2 (7.1%)</td>
<td>0 (0%)</td>
<td>2 (7.1%)</td>
<td>2 (7.1%)</td>
<td>22 (78.6%)</td>
<td>28</td>
</tr>
</tbody>
</table>

**Table 20**

*Largest to Smallest Referral Sources for Clients at Participants’ Treatment Location*

<table>
<thead>
<tr>
<th>Referral Sources</th>
<th>1(^{st}) (Largest)</th>
<th>2(^{nd})</th>
<th>3(^{rd})</th>
<th>4(^{th})</th>
<th>5(^{th})</th>
<th>6(^{th}) (Smallest)</th>
<th>( (N = 110) ) Total Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals from schools</td>
<td>11 (13.6%)</td>
<td>13 (16%)</td>
<td>25 (30.9%)</td>
<td>16 (13.6%)</td>
<td>11 (13.6%)</td>
<td>5 (6.2%)</td>
<td>81</td>
</tr>
<tr>
<td>Referrals from courts</td>
<td>6 (8.6%)</td>
<td>7 (10%)</td>
<td>10 (14.3%)</td>
<td>16 (22.9%)</td>
<td>12 (17.1%)</td>
<td>19 (27.1%)</td>
<td>70</td>
</tr>
<tr>
<td>Referrals from other mental health professionals</td>
<td>33 (33%)</td>
<td>33 (33%)</td>
<td>22 (22%)</td>
<td>6 (6%)</td>
<td>2 (2%)</td>
<td>4 (4%)</td>
<td>100</td>
</tr>
</tbody>
</table>
Table 20—Continued

<table>
<thead>
<tr>
<th>Referral Sources</th>
<th>1&lt;sup&gt;st&lt;/sup&gt; (Largest)</th>
<th>2&lt;sup&gt;nd&lt;/sup&gt;</th>
<th>3&lt;sup&gt;rd&lt;/sup&gt;</th>
<th>4&lt;sup&gt;th&lt;/sup&gt;</th>
<th>5&lt;sup&gt;th&lt;/sup&gt;</th>
<th>6&lt;sup&gt;th&lt;/sup&gt; (Smallest)</th>
<th>(N = 110) Total Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals from a church/religious group</td>
<td>3 (4.3%)</td>
<td>6 (8.6%)</td>
<td>7 (10%)</td>
<td>11 (15.7%)</td>
<td>25 (35.7%)</td>
<td>18 (25.7%)</td>
<td>70</td>
</tr>
<tr>
<td>Self-Advertising or Marketing (Online, Phonebook, Newspaper, Magazine, Flyers, Billboard, etc.)</td>
<td>33 (36.7%)</td>
<td>24 (26.7%)</td>
<td>10 (11.1%)</td>
<td>12 (13.3%)</td>
<td>6 (6.7%)</td>
<td>5 (5.6%)</td>
<td>90</td>
</tr>
<tr>
<td>Other</td>
<td>27 (40.9%)</td>
<td>10 (15.2%)</td>
<td>9 (13.6%)</td>
<td>3 (4.5%)</td>
<td>4 (6.1%)</td>
<td>13 (19.7%)</td>
<td>66</td>
</tr>
</tbody>
</table>

Phase II

Of the nine Phase II participating treatment teams, length of experience facilitating EAGALA-model EAP ranged from two months to eleven years among individual providers. Educational backgrounds of the mental health professionals (MHPs) ranged from master’s degrees in social work, family therapy, mental health counseling, and psychology to doctoral degrees in psychology and from high school diplomas to bachelor’s degrees for equine specialists (ESs). Treatment settings varied from outpatient therapy to residential and educational programs. Further, the primary theoretical orientation of MHPs included Experiential (n = 4), Cognitive Behavioral (n = 2), Humanistic (n = 2) and Psychodynamic (n = 1).

As part of Phase II research, participants were asked to measure their adherence to prescribed and proscribed EAGALA-model EAP behaviors during practice using the
EAP-TIC. The EAP-TIC specifically required participants to rate the frequency with which they engaged in the included 18 behaviors during EAGALA-model EAP sessions and to subjectively rate how much the client(s) engaged in the therapy process, appeared to value the treatment, were able to relate in-session experiences to their life, and/or expressed oppositional behavior.

The 18 EAP-TIC behavior ratings were collapsed into dichotomous categories (i.e., occurred or not occurred) and analyzed for inter-rater reliability using two-way random intra-class correlation coefficients (ICC) (Shrout & Fleiss, 1979). ICCs are descriptive statistics indicating the degree to which raters score observations in a similar manner. As with other measures of reliability, ICC values range from 0 to 1.0; higher numbers indicating stronger reliability. For the purposes of this study, Cicchetti’s (1994) guidelines for interpreting the level of clinical significance for ICCs will be used where values between 0 and 0.4 are considered to have “poor” reliability, values between 0.4 and 0.6 are “fair,” those between 0.6 and 0.8 fall within the “good” range, and values above 0.8 are considered “excellent.” Because only half of the audios were coded by three raters (i.e., participant, researcher, and independent observer) and the remaining were coded by only the participant and researcher, two separate ICC values were obtained for each EAP-TIC item. These two ICC values were then averaged to generate a mean ICC for each EAP-TIC item. Unfortunately, because ICCs cannot be calculated when there is no variation among one rater’s codes (i.e., one rater codes all audio sessions as including an EAP-TIC item at least once or does not code the item as occurring in any of
the sessions), these values could not be determined for 4 items. The mean ICC values for another ten items were calculated using only the portion of audios for which there was sufficient variance in rater’s codes to generate an agreement score.

Additionally, Cohen’s kappa (Cohen, 1968) coefficients ($k$) were calculated to provide a metric of inter-rater reliability that theoretically accounts for random occurrence of rating agreement. However, because $k$ can only be determined for pairs of raters, mean values from multiple comparisons were calculated. For the purposes of this study, Landis and Koch’s (1977) classification system of $k$ values between 0 and 0.20 being considered as having “slight” agreement, 0.21 to 0.40 as “fair,” 0.41 to 0.60 as “moderate,” 0.61 to 0.80 as “substantial,” and 0.81 to 1.00 as “almost perfect” agreement will be used. Due to the fact that $k$ cannot be calculated when there is no variation among one rater’s reported codes (i.e., one rater codes all audio sessions as including an EAP-TIC item at least once or does not code the item as occurring in any of the sessions), $k$ values could not be determined for 3 items.

Finally, a simple percent agreement across raters (i.e., the number of audio recordings for which all raters agreed on the occurrence or non-occurrence of a behavior) was determined for each of the 18 EAP-TIC items. This calculation, although crude, is considered to be the “most popular index for describing interobserver agreement” (as reported in Watkins & Pacheco, 2000, p. 207). Percent agreement scores are not impacted by lack of variation in rater’s coding and therefore allowed for calculation of all rater’s codes on all 18 EAP-TIC items across all 20 sessions. This value
shows the proportion for which all raters agreed that a behavior occurred or did not occur during each session.

Obtained statistics, including all ICCs, mean k coefficients, and mean percent agreement varied across all 18 EAP-TIC items, and are presented below in Table 21. Item performance with respect to each metric is indicated by asterisks with explanations below the table.

**Table 21**

*EAP-TIC Items With Obtained ICC, Kappa, and Percent Agreement Values*

<table>
<thead>
<tr>
<th>EAP-TIC Item</th>
<th>ICC of EAP-TIC Item with 3 Coders</th>
<th>ICC of EAP-TIC Item with 2 Coders</th>
<th>Mean ICC from available</th>
<th>Mean Kappa</th>
<th>Mean Percent Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Use of Metaphors</td>
<td>0.00</td>
<td>†</td>
<td>N/A</td>
<td>N/A</td>
<td>.97</td>
</tr>
<tr>
<td>2 Use of Projection</td>
<td>.538</td>
<td>†</td>
<td>.54*</td>
<td>.28</td>
<td>.90</td>
</tr>
<tr>
<td>3 Use of Socratic Questioning</td>
<td>0.00</td>
<td>†</td>
<td>N/A</td>
<td>N/A</td>
<td>.93</td>
</tr>
<tr>
<td>4 Use of Reflective Listening</td>
<td>†</td>
<td>†</td>
<td>N/A</td>
<td>N/A</td>
<td>1.0</td>
</tr>
<tr>
<td>5 Use of Clean/Objective Language</td>
<td>.750</td>
<td>†</td>
<td>.75**</td>
<td>1.0***</td>
<td>.95</td>
</tr>
<tr>
<td>6 Encouragement of Skills Generalization</td>
<td>.609</td>
<td>†</td>
<td>.61**</td>
<td>.74**</td>
<td>.83</td>
</tr>
<tr>
<td>7 Focus on Client Strengths</td>
<td>.375</td>
<td>†</td>
<td>.38</td>
<td>.17</td>
<td>.72</td>
</tr>
<tr>
<td>8 Tolerance of Failures, Frustrations, Challenges, Obstacles</td>
<td>n/a†</td>
<td>†</td>
<td>N/A</td>
<td>0.00</td>
<td>.55</td>
</tr>
<tr>
<td>9 Incorporation of Treatment Goals or Presenting Problem into Activities</td>
<td>.471</td>
<td>1.0</td>
<td>.74**</td>
<td>.52*</td>
<td>.67</td>
</tr>
<tr>
<td>10 Acknowledgment of Shifts</td>
<td>.333</td>
<td>†</td>
<td>.33</td>
<td>.29</td>
<td>.75</td>
</tr>
<tr>
<td>11 Acknowledgment of Patterns</td>
<td>.625</td>
<td>.471</td>
<td>.55*</td>
<td>.35</td>
<td>.68</td>
</tr>
<tr>
<td>12 Acknowledgment of Uniqueness</td>
<td>.226</td>
<td>n/a†</td>
<td>.23</td>
<td>.08</td>
<td>.50</td>
</tr>
<tr>
<td>13 Acknowledgment of Discrepancies</td>
<td>n/a†</td>
<td>.471</td>
<td>.47*</td>
<td>.11</td>
<td>.58</td>
</tr>
<tr>
<td>14 Interfering with Client's Growth &amp; Learning</td>
<td>.478</td>
<td>†</td>
<td>.48*</td>
<td>.52*</td>
<td>.70</td>
</tr>
</tbody>
</table>
Table 21—Continued

<table>
<thead>
<tr>
<th>EAP-TIC Item</th>
<th>ICC of EAP-TIC Item with 3 Coders</th>
<th>ICC of EAP-TIC Item with 2 Coders</th>
<th>Mean ICC from available</th>
<th>Mean Kappa</th>
<th>Mean Percent Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 Criticizing, Judging, Blaming, or Being Confrontational with Client</td>
<td>.250</td>
<td>†</td>
<td>.25</td>
<td>.21</td>
<td>.78</td>
</tr>
<tr>
<td>16 Use of Non-Clean/Subjective Language</td>
<td>.143</td>
<td>.640</td>
<td>.39</td>
<td>.16</td>
<td>.55</td>
</tr>
<tr>
<td>17 Focus on Product or Outcome of Activity (Rather than Process)</td>
<td>.400</td>
<td>1.0</td>
<td>.70**</td>
<td>.37</td>
<td>.70</td>
</tr>
<tr>
<td>18 Focus on Horsemanship or Riding</td>
<td>†</td>
<td>1.0</td>
<td>1.0***</td>
<td>1.0***</td>
<td>1.0</td>
</tr>
</tbody>
</table>

*Met criteria for “fair” clinical significance according to Cicchetti (1994) guidelines for ICCs, or “moderate” reliability according to Landis and Koch (1977) guidelines for kappa coefficients.

** Met criteria for “good” clinical significance according to Cicchetti (1994) guidelines for ICCs, or “substantial” reliability according to Landis and Koch (1977) guidelines for kappa coefficients.

***Met criteria for “excellent” clinical significance according to Cicchetti (1994) guidelines for ICCs, or “almost perfect” reliability according to Landis and Koch (1977) guidelines for kappa coefficients.

†Item showed insufficient variability to generate a non-zero ICC value (at least one coder rated all audios as having met criteria at least once).

“n/a” or “N/A” ICCs could not be calculated due to insufficient variance (N/A) or covariance (n/a).

Mean ratings for the four additional EAP-TIC questions, which asked participants to indicate their subjective impression of how much the client (1) engaged in the treatment process, (2) expressed oppositional behavior, (3) successfully generalized experiences, and (4) benefitted from treatment during their therapy session are presented in Table 22. Four ranking options (i.e., 1 = Little to None, 2 = Some, 3 = Much, and 4 = A Lot) were available for these questions.
Table 22

Mean Ratings Across All Sessions for Additional EAP-TIC Questions

<table>
<thead>
<tr>
<th>EAP-TIC Question: “Indicate you subjective impression of how much the client ______ during the session based on your observation of his/her in-session behavior.”</th>
<th>Mean Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engaged in Treatment Process</td>
<td>3.03</td>
</tr>
<tr>
<td>Exhibited/Expressed Oppositional Behavior</td>
<td>1.35</td>
</tr>
<tr>
<td>Successfully Generalized Experiences</td>
<td>2.59</td>
</tr>
<tr>
<td>Benefitted from Treatment</td>
<td>2.84</td>
</tr>
</tbody>
</table>

Note. 1 = Little to None, 2 = Some, 3 = Much, 4 = A Lot.

Table 23 shows the number of sessions in which each EAP-TIC behavior occurred at least once in the 20 Phase II sessions. As presented, the most frequently occurring prescribed therapist behaviors included on the EAP-TIC were use of metaphors, Socratic questioning, and reflective listening, which were coded in 20 of 20 sessions by the participants and rater. Use of Projection, clean/objective language, and encouragement of skills generalization were coded as occurring in at least 18 of 20 sessions by the participants and rater. Focus on client strengths was coded in at least 15 of 20 sessions by the participants and rater. Acknowledgment of shifts and patterns occurred in moderation and acknowledgment of uniqueness and discrepancies were the least commonly utilized prescribed behaviors.

In terms of the proscribed behaviors included on the EAP-TIC, participants and raters coding varied more widely. For example, participants indicated that interfering with client’s growth and learning and criticizing, judging, blaming or being confrontational with the client did not occur in any of the 20 sessions; however, the
rater coded these behaviors as happening in 7 and 3 of the sessions, respectively. Use of non-clean/subjective language and focus on the product or outcome of the activity was coded as occurring more frequently, 15 and 8 times by the rater and 6 and 2 times by the participants, respectively. Finally, participants and the rater agreed that Focus on Horsemanship was evidenced in only one session.

Table 23

*Number of Sessions in Which EAP-TIC Behavior Occurred at Least Once, as Coded by Participants and Rater*

<table>
<thead>
<tr>
<th>EAP-TIC Item</th>
<th>Participant</th>
<th>Rater</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of Metaphors</td>
<td>20/20</td>
<td>20/20</td>
</tr>
<tr>
<td>Use of Projection</td>
<td>19/20</td>
<td>20/20</td>
</tr>
<tr>
<td>Use of Socratic Questioning</td>
<td>20/20</td>
<td>20/20</td>
</tr>
<tr>
<td>Use of Reflective Listening</td>
<td>20/20</td>
<td>20/20</td>
</tr>
<tr>
<td>Use of Clean/Objective Language</td>
<td>20/20</td>
<td>19/20</td>
</tr>
<tr>
<td>Encouragement of Skills Generalization</td>
<td>20/20</td>
<td>18/20</td>
</tr>
<tr>
<td>Focus on Client Strengths</td>
<td>18/20</td>
<td>15/20</td>
</tr>
<tr>
<td>Tolerance of Failures, Frustrations, Challenges, Obstacles</td>
<td>20/20</td>
<td>13/20</td>
</tr>
<tr>
<td>Incorporation of Treatment Goals or Presenting Problem into Activities</td>
<td>18/20</td>
<td>14/20</td>
</tr>
<tr>
<td>Acknowledgment of Shifts</td>
<td>20/20</td>
<td>13/20</td>
</tr>
<tr>
<td>Acknowledgment of Patterns</td>
<td>18/20</td>
<td>11/20</td>
</tr>
<tr>
<td>Acknowledgment of Uniqueness</td>
<td>12/20</td>
<td>4/20</td>
</tr>
<tr>
<td>Acknowledgment of Discrepancies</td>
<td>12/20</td>
<td>7/20</td>
</tr>
<tr>
<td>Interfering with Client's Growth &amp; Learning</td>
<td>0/20</td>
<td>7/20</td>
</tr>
<tr>
<td>Criticizing, Judging, Blaming, or Being Confrontational with Client</td>
<td>0/20</td>
<td>3/20</td>
</tr>
<tr>
<td>Use of Non-Clean/Subjective Language</td>
<td>6/20</td>
<td>15/20</td>
</tr>
<tr>
<td>Focus on Product or Outcome of Activity (Rather than Process)</td>
<td>2/20</td>
<td>8/20</td>
</tr>
<tr>
<td>Focus on Horsemanship or Riding</td>
<td>1/20</td>
<td>1/20</td>
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</table>
DISCUSSION

The purpose of this study was to examine the program operations and treatment practices of individuals and organizations providing equine-assisted therapy services nationwide. The web-based survey included in Phase I served as an instrument for collecting exploratory, descriptive information about the major components of equine-assisted therapy from treatment providers including those related to service implementation, use of evidence-based practices, use of standardized outcome measures, fidelity to training protocols and consumer demographics. Phase II focused on further assessment of treatment delivery by providers trained specifically in EAGALA-model EAP. Particularly, researchers were interested in determining whether or not the EAP-TIC could serve as a reliable treatment integrity measure for use in practice and research settings. In addition, the EAP-TIC was used to capture, in a small sample, the extent to which trained providers are actually engaging in prescribed EAGALA-model behaviors and not engaging in proscribed behaviors during their routine EAP practice.

Phase I

Findings suggested that the majority of participants in this study practiced EAGALA-model EAP, either exclusively or in addition to other equine-assisted therapy approaches in which they were trained. However, due to the specific recruitment strategies used in this study and the fact that members of this organization are encouraged and assisted in marketing their services, EAGALA treatment providers were
likely more heavily targeted during online searches than providers of other less-widely-known equine-assisted models. Nonetheless, participants appeared to represent a range of training backgrounds and professional experiences, which can be considered a fair representation of the larger population of equine-assisted therapy providers nationwide.

Few participants who identified themselves as mental health professionals indicated they offered equine-assisted therapy services only; rather, most also practiced in traditional, office-based therapy settings at least part-time. This finding, when added to other ancillary information gleaned, seemed to suggest that there may be an insufficient consumer base to necessitate and sustain full-time work in the field of equine-assisted therapy at present. The reasons for this are likely numerous to include the cost of services both for providers and consumers inasmuch as equine-assisted therapy is seldom reimbursed by private insurance or public aid, as is customary with many traditional therapies. Consequently, consumers interested in this modality are forced to pay for treatment out-of-pocket, obtain other third-party funding, or agree to an alternative therapy approach covered by their insurance provider. Further, many equine-assisted treatment providers pursue grant-funding and donations from their community in an effort to minimize costs for clients who simply cannot afford this type of therapy. These barriers continue to limit the number of consumers who have reasonable access to non-traditional psychotherapy approaches such as equine-assisted therapy.
In a health delivery system becoming increasingly emphatic about the use of evidence-based practices, it is conceivable that lack of empirical support bears blame for equine-assisted therapies continuing to be excluded from insurance coverage plans. In accordance with the evidence-based movement, treatment providers must rise to the challenge and be accountable for their efficiency and effectiveness by demonstrating, in an empirical fashion, the outcomes of their work. However, in order to accomplish this mission, practitioners must first be able to provide an accurate description of the intervention, to objectively measure it, and also to identify the mechanism(s) of change involved. The current study aimed to bring the field of equine-assisted therapy one step closer to this goal.

The existence of internally consistent treatment concepts and techniques for equine-assisted therapies was first gauged by determining the theoretical orientations that best inform participants’ clinical approaches, followed by a more in-depth assessment of the particular strategies they commonly used while conducting therapy. Given that equine-assisted therapy is considered an experiential treatment, it came as no surprise that the bulk of clinicians identified themselves as being grounded in Experiential theory. The second largest theoretical orientation selected by participants was Cognitive Behavioral theory, Gestalt theory was third, Behavioral theory was fourth, and Eclectic and Interpersonal theories tied for fifth. This range in conceptual models seems to support the “metatheoretical” quality of equine-assisted therapy and lends itself to flexibility within clinicians’ style of treatment delivery. Nonetheless, certain
treatment concepts and techniques were found consistently across equine-therapy programs. For example, when offered a selection of treatment strategies commonly found in empirically supported approaches, participants, on average, reported use of problem-solving and/or decision-making skills training, emotion regulation skills training, and cognitive restructuring most frequently (i.e., to at least a moderate extent) in their individual equine-assisted therapy practice. Furthermore, when participants were asked to describe the extent to which they would use a broad range of techniques found in multiple treatment approaches with two hypothetical clients (i.e., an adult with depression and an adolescent with oppositional and conduct issues), many of the most frequently endorsed techniques were cognitive or behavioral in nature. This finding is encouraging since “the most commonly used evidence-based practice approaches for the treatment of psychological symptoms involve cognitive and behavior therapies” (“What is Evidence-Based Practice?,” n.d.). In other words, even those clinicians who do not formally consider themselves guided by cognitive and behavioral theories appear to be using cognitive and behavioral strategies, many of which are found in empirically supported treatments, during their equine-assisted therapy sessions. This information, although not unexpected by the researcher, seems to contrast with the view held and supported by many professionals: that equine-assisted therapy is a wholly unique model distinctly different from other available treatment modalities. More accurately, however, it appears that equine-assisted therapy combines active ingredients already shown to be effective in the traditional therapy context with innovative, experiential
elements offered in a disarming setting. Such a recipe has the potential to enhance existing outcome results and therefore warrants further empirical study.

Use of techniques found to be effective is a necessary but not sufficient component of efficacious therapy. Another action considered essential in effective treatment is continual monitoring of client progress. The integration of progress evidence into treatment, through the use of instruments or scales or by regularly checking in with the client, allows for objective assessment about whether the treatment is working or needs to be modified to more closely match the client’s idiographic needs. Further, progress monitoring is consistent with evidence-based practice standards and ethical guidelines for mental health professionals and allows practitioners to be accountable for their work.

Participants of the current study were asked to specify how progress data were collected within their equine-assisted therapy programs. Over 80% of survey takers indicated they regularly monitor client progress, either using standardized outcome measures or informal feedback, and many collect information from multiple sources (e.g., parents, teachers, caseworkers, parole/probation officers, the court, or other treatment provider). In a survey conducted by Hatfield and Ogles (2004), a national sample of nearly 1,000 APA-member psychologists were investigated regarding their use of outcome measures in clinical practice. “In response to the question, “Do you use some form of outcome assessment in your practice?” 37.1% stated that they did (62.9% did not)” (Hatfield & Ogles, 2004). This suggests that the sample of equine-assisted
therapy providers from the current study are engaging in progress monitoring at more than double the rate of general practitioners. Additionally, more than 57% of participants reported use of standardized assessments including objective and projective personality measures, intelligence and achievement tests, behavioral rating scales and self-report measures, neuropsychological tests, and trauma based instruments to assist with individualized treatment planning. This information is reassuring, as it supports the idea that equine-assisted therapy providers are engaging in behaviors consistent with the spirit of evidence-based practice.

More promising yet, was the feedback obtained by participants regarding their feelings and beliefs about adopting new types of therapy, including manualized interventions. In their responses to questions borrowed from the Evidence-Based Practice Attitude Scale (EBPAS) (Aarons, 2004), participants, on average, showed a general openness to trying new interventions and a willingness to try or use evidence-based practices, particularly if the approach was intuitively appealing, made sense, could be used correctly, was being used by colleagues who were happy with it, and/or was required by their state or agency.

Another treatment concept found to be consistent across programs was participants’ beliefs about why horses are an important feature of therapy. Findings from the current study indicated that the majority of equine-assisted therapy providers, regardless of their theoretical framework, view the horse as central to the model in large part due to its ability to read and sense humans’ feelings and emotions, which it
seemingly mirrors back to the client. This process of “mirroring” between the horse and client is functionally equivalent to the immediate feedback provided by therapists to clients in other forms of therapy. Given their history as prey animals, horses are innately sensitive to physiological changes in their herd mates, particularly those suggestive of fear (i.e., increases in heart rate, blood pressure or breathing). It is this instinct that also allows them to be extraordinarily sensitive to humans’ physiological and emotional responses in the therapy setting. If a client’s verbal behavior is incongruent with their body language, the horse will sense this and instinctively respond to the client’s nonverbal communication. Assuming this will not result in the response the client was looking for, he/she will immediately receive feedback suggesting their strategy was unsuccessful. Over time, the client’s behavior changes (i.e., learning occurs) as a function of building associations between stimulus and response events with the horse (Burton, Moore, & Magliaro, 1996). Essentially, the horse serves as an active provider of social reinforcement (i.e., a mediator of reinforcement), which facilitates change. What the client stands to learn is that their intentions, thoughts, words, body language, and physiology must be congruent in order to successfully communicate with the horse and obtain their desired outcomes. Learning the interrelationship between thoughts, feelings, and behaviors through active engagement with horses is only the first half of the goal, however. Eventually, in session behavior changes must generalize to settings and situations outside treatment. Generalization is a critical factor and serves as an indicator of therapy effectiveness (Borrego & Urquiza, 1998).
Equine-assisted therapy clients benefit from the synergistic effect of building a therapeutic relationship with two central agents of behavior change: the horse and the therapist. The result, according to Phase I participants, is improved verbal and nonverbal communication; an increased sense of empowerment and heightened self-esteem, self-efficacy, and self-confidence; and the development of more effective coping skills. Collectively, these treatment gains, if appropriately generalized, lead to improved overall mental health and quality of life for consumers.

Phase II

Overall, the findings of the present study suggest promise in the ability to operationalize the EAGALA-model of EAP. Furthermore, the EAP-TIC appears to be a reliable treatment integrity measure and a useful tool for evaluating the facilitation skills of trained EAGALA-model service providers. Assessing how an intervention is implemented helps determine whether the components identified as critical to the success of the treatment are actually being applied in routine practice, and allows for empirical evaluation about whether or not the intervention is being executed effectively. An assessment measure such as the EAP-TIC can aid investigators in this research process and can also support practitioners’ efforts to remain accountable in their daily work with consumers.

In the present study, many of the 18 EAP-TIC items achieved fair to excellent agreement across the various measures of reliability. Although lack of variation among
raters’ coding prevented the calculation of ICC and Kappa values for several items, percent agreement values, specifically, demonstrated that a majority of the 18 EAP-TIC items were highly reliable, some showing perfect agreement. This indicates that individual raters in both clinical and research settings often concurred on the presence or absence of critical therapist behaviors during EAGALA-model equine-assisted therapy sessions. Therefore, generally-speaking, the EAP-TIC appears to be a reliable treatment integrity measure.

Nevertheless, further refinement of the current EAP-TIC may improve its psychometric properties and increase its utility in research and practice settings. For example, one characteristic of the instrument that may benefit from modification is how the 18 EAP-TIC items are defined and how users are trained to code included items. At present, items are accompanied by a basic topographical and functional description; however, a more detailed explanation of the therapeutic purpose of each item may be necessary, particularly when the instrument is being used by inexperienced therapists, non-mental health professionals (i.e., equine specialists or other members of the treatment team), individuals not trained in the EAGALA-model, or those with limited understanding of the function underlying pertinent therapeutic skills such as Socratic questioning, reflective listening, and/or projection. In addition, individual users of the EAP-TIC may benefit from a supplemental manual that includes comprehensive explanations, examples, and decision rules for each item to assist in the overall coding process.
Refinement of the current EAP-TIC should also include systematic review by experts in EAGALA-model EAP. Analysis and feedback from clinicians trained in this relatively new approach can help to determine which, if any, items need to be added, removed, or altered before promoting it for widespread use among EAGALA practitioners.

Based on data obtained in Phase II, it appears that many of the components identified as critical to the EAGALA-model are being utilized and performed during sessions. While some of the more commonly occurring EAP-TIC items are general therapy strategies found in a variety of interventions, use of shifts, patterns, uniqueness, and discrepancies (i.e., SPUD’s) are unique to the EAGALA-model. Although the frequency with which these four items occurred during all twenty sessions varied between participant and rater (see Table 23) they are considered fundamental to the intervention. Purposed explanations for disagreement in the coding of these and other EAP-TIC items are discussed below.

LIMITATIONS

Phase I

As with any self-report measure, data from the web-based survey must be considered with caution. Results may be impacted by the social desirability of participants and the inherent bias produced by those who did not respond to the survey itself or to individual items within the survey. As reported, many participants chose not
to answer several of the survey questions, causing a decrease in the sample size and therefore the generalizability of the findings.

Phase II

A notable limitation of the study was the relatively small sample size. For this reason, findings may not be generalizable to the greater community of EAGALA-model EAP service providers. However, based on the results of this small scale study, future studies utilizing a much larger sample appear warranted.

Additionally, poor audio quality impacted the ability of raters to hear all the dialogue occurring during participants’ EAP sessions. It is possible that during portions of inaudible audio, certain EAP-TIC behaviors were elicited by therapists but unable to be coded, thereby impacting the accuracy of EAP-TIC reliability ratings. Similarly, a few of the EAP-TIC items may have been difficult to capture via audio recording (e.g., tolerance of failures, frustrations, challenges, obstacles and interfering with client’s growth and learning), which may account for some of the disagreement in coding for these particular behaviors.

Another limitation of the current study arises from the difference in the way participants, independent observers, and the researcher completed the EAP-TIC. Specifically, participants were asked to fill out the EAP-TIC immediately following their recorded sessions; however, independent observers and the researcher completed the instrument while simultaneously listening to the audio recordings. As a result, variations
in occurrence versus non-occurrence of behaviors between participants and observers may be due to inherent differences in recall versus immediate memory, respectively.

Furthermore, differences between participants and independent observers in their knowledge of the EAGALA-model and extent of training and instruction in use of the EAP-TIC may have impacted results. For example, independent observers were undergraduate and graduate level psychology students with no formal training in the EAGALA-model or any equine-assisted therapy approach. Consequently, their knowledge of EAGALA-specific concepts such as shifts, patterns, uniqueness, and discrepancies (i.e., SPUD’s) or clean versus non-clean language was limited to that presented by the researcher through informal training. Similarly, Phase II participants did not receive the same level of training as independent observers in how to appropriately code behaviors using the EAP-TIC. For example, independent observers were provided with an array of training materials offering additional descriptions and examples of all EAP-TIC items, extensive feedback after coding practice sessions, and were able to clarify any questions or concerns about coding with the researcher. In contrast, Phase II participants were given only the basic instructions provided on the EAP-TIC form itself. One notable issue that may have resulted from this difference in training is the dissimilarity in what behavior and content was coded within a therapy session. For instance, independent observers were trained to code behavior occurring during dialogue between the EAP facilitators (MHPs and ESs) and the client(s) and not to code behavior elicited during the quiet, private conversations between MHPs and ESs
during sessions. As part of the EAGALA-model, facilitators are trained to work in close proximity to one another during sessions and to make observations and identify themes that can assist in a client’s therapeutic process. However, it is the researcher’s assumption that unless these observations and themes are conveyed to the client, either directly or indirectly, they have minimal impact or benefit to the individual. Based on some of the participants’ EAP-TIC ratings and the content of their audio recordings, it is believed that this distinction was not made clear and therefore, behavior emitted during these private conversations between facilitators was coded, which may have inadvertently skewed the reliability results.

Further, inherent limitations of self-report data likely impacted Phase II results. The EAP-TIC is a largely transparent instrument requiring participants to rate the frequency with which they engaged in prescribed and proscribed EAGALA-model behaviors. Due to participants’ conscious or unconscious attempts to present a certain impression, socially desirable responding may have occurred. Obtaining EAP-TIC ratings from independent observers was an attempt to counteract this intrinsic weakness.

Overall, the results of this study are promising. It is the author’s goal to continue exploring the field of equine-assisted therapy and the EAGALA-model to determine whether or not such interventions are effective in treating particular disorders and psychosocial concerns in various client populations.
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Appendix A

Web-Based Equine Therapy Programming Survey and Consent to Participate in Phase I Survey (embedded within first screen of online survey)
Welcome to the online survey for the research project entitled “Equine-Assisted Therapy: A Descriptive Study,” which is designed to examine the program operations and treatment practices of individuals and organizations providing equine therapy services nationwide. Any equine therapy service provider within the United States is eligible to participate in this study; no additional criteria are necessary.

The survey is comprised of several closed and open-ended questions and will take you approximately 35 minutes to complete. Your replies will be completely anonymous, so do not put your name anywhere within the survey. You may choose to not answer any question and simply leave the response blank. Submitting the survey indicates your consent for use of the answers you supply.

All of the information collected from you during this study will only be accessed by those involved in the research (i.e., primary and student investigator, research assistants). While there are no known risks or direct benefits to participants, the information you provide will add to the existing database of knowledge on equine therapy programming nationwide. As a small gesture of appreciation for your participation, you may choose to be entered into a drawing for a chance to win one of two gift cards in the amount of $50. If you have any questions, you may contact Dr. Amy Naugle at 269-387-4726, Erica Jex Gergely, M.A. at 716-523-1359, the Human Subjects Institutional Review Board (269-387-8239) or the vice president for research (269-387-8298).

You may save your responses and return to the survey for completion at a later time; however, you must use the same computer and internet browser in order for your saved responses to appear.

In order to progress through this survey, please use the following navigation buttons:

- Click the Next button to continue to the next page.
- Click the Previous button to return to the previous page.
- Click the Exit the Survey Early button if you need to exit the survey.
- Click the Submit button to submit your survey.
Web Based Equine Therapy Programming Survey

Instructions Part I: Please read and respond to the following questions using the specific instructions provided for each. Questions in this section refer to you, as an individual service provider.

1. Are you an equine therapy service provider?
   a. Yes
   b. No

2. What type of equine therapy services do you, personally, provide? Please check all that apply.
   a. EAGALA-model EAP
   b. Non-EAGALA-model EAP
   c. Equine-Assisted Learning (EAL)
   d. Equine-Assisted Therapy (EAT)
   e. Equine Facilitated Therapy (EFT)
   f. Equine Facilitated Psychotherapy (EFP)
   g. Equine-Assisted Counseling (EAC)
   h. Equine Experiential Learning (EEL)
   i. Equine Facilitated Learning (EFL)
   j. Equine Facilitated Mental Health (EFMH)
   k. Equine-Assisted Mental Health (EAMH)
   l. Equine-Facilitated Growth and Learning (EFG/EFL)
   m. Therapeutic Riding
   n. Other: ______ (fill in)

3. What is the highest level of EAGALA certification training you have completed? (Only shown for those who select EAGALA-model EAP/L in Question 2)
   a. EAGALA Part I/Level I
   b. EAGALA Part II/Level II
   c. EAGALA Advanced Certified
   d. I have not completed any EAGALA certification trainings

4. Are you a member of the organization of EAGALA (i.e., current on your membership requirements and annual dues)?
   a. Yes
   b. No
5. Are you the mental health professional (MHP), equine specialist (ES), both, or “other” part of the equine therapy team?
   a. MHP
   b. ES
   c. Both
   d. Other title: _____ (fill in)

6. Please select the following statement that best reflects your work as a mental health professional: (Only shown for those who select MHP in Question 5)
   a. I provide equine therapy services exclusively (I do not offer traditional, office-based therapy)
   b. I own an independent practice where I provide equine therapy services as an adjunct to traditional, office-based therapy
      a. If checked ask:
         a) (#7) How do you determine which clients should pursue equine therapy services?
         b) (#8) How do you determine which session will be held in the barn/arena and which will be held in the office?
   c. I own an independent practice where I see some clients in the barn/arena for equine therapy and some in a traditional office setting. I do not see the same clients for both traditional, office-based therapy and equine therapy, it is either/or.
   d. I own an independent practice where I sometimes see the same clients for traditional, office-based therapy and equine therapy. I mix therapy settings with the same clients.
   e. I have two separate jobs as a mental health professional. I work for a company/agency where I see clients in more of a traditional therapy setting and I also work for a separate equine therapy organization.
   f. Other situation: (Please explain)

9. How long have you been providing equine therapy services?
   a. Less than 6 mos.
   b. 6 mos-1 year
   c. 1-2 years
   d. 2-3 years
   e. 3-5 years
   f. 5-10 years
   g. 10+ years
10. What is the highest educational degree you have obtained?
   a. Associate’s Degree
   b. Bachelor’s Degree
   c. Master’s Degree
   d. Doctorate Degree
   e. Medical Degree
   f. Other: _____(fill in)

11. What theoretical orientation(s) best informs your treatment/clinical approach for equine therapy sessions? Rank up to three options that best reflect your practice (1-primary, 2-secondary, 3-tertiary).
   a. Adlerian
   b. Behavioral
   c. Cognitive
   d. Cognitive Behavioral
   e. Existential
   f. Experiential
   g. Eclectic
   h. Gestalt
   i. Humanistic
   j. Interpersonal
   k. Psychodynamic
   l. Rogerian
   m. Transtheoretical
   n. Faith-Based
   o. Other: _____(fill in)

12. To what extent do you use the following intervention strategies during equine therapy sessions? Indicate the extent of use for each strategy using the following scale 1=not at all, 2=to a slight extent, 3=to a moderate extent, 4=to a great extent, 5=to a very great extent
   a. Identifying Cognitive Errors
   b. Cognitive Restructuring
   c. Problem-Solving and/or Decision-Making skills training
   d. Experiential Avoidance Prevention
   e. Emotion Regulation Skills Training
   f. Exposure and Response Prevention
   g. Modeling/Imitation
   h. Behavioral Rehearsal/Role-Play
   i. Relaxation and/or Breathing Training
   j. Socratic Questioning
   k. Graded Task Assignments
   l. Examining the Evidence
   m. Activity and Pleasant Events Scheduling
13. Do you work with adults with depression in your equine therapy practice?
   a. Yes
   b. No

14. If you were to work with an adult client with depression in your equine therapy practice, how likely would you be to use the following techniques during a session? (1=not at all, 2=to a slight extent, 3=to a moderate extent, 4=to a great extent, 5=to a very great extent)
   a. Cognitive restructuring
   b. Behavioral activation strategies
   c. Activity and pleasant events scheduling
   d. Mindfulness exercises
   e. Empty-chair exercises
   f. Therapeutic metaphors
   g. Assignment of homework
   h. Relaxation exercises
   i. Encourage client to try new behaviors
   j. Maintain a strong focus on therapist-client relationship
   k. Attempt to identify the cause of the depressive symptoms
   l. Focus on mastering the client’s awareness
   m. Discussion of the interrelationship between thoughts, feelings, and behaviors
   n. Encourage client not to allow negative rewards to dictate their behavior
   o. Have client distinguish between their thoughts and feelings
   p. Learn about clients thoughts that seem to occur automatically
   q. Evaluate whether clients automatic thoughts are accurate or perhaps biased
   r. Help client to develop skills to notice, interpret, and correct biased thoughts
   s. Focus on early learning experiences that may be related to depression
   t. Focus on the factors that are currently maintaining the depressive behaviors
   u. Encourage client to work on accepting and/or tolerating painful emotions
   v. Reflection and clarification of client’s verbal and non-verbal behavior
   w. Focus on self-realization through here-and-now experiments in directed awareness
   x. Teach client strategies to promote more effective problem-solving and decision-making
   y. Focus on how some thoughts or behaviors might get “rewarded” within client’s environment
   z. Focus on childhood and previous life experiences that may be impacting or maintaining depressive behaviors
   aa. Encourage client to engage in activities that promote a sense of pleasure or mastery inside and outside of sessions
   bb. Help client to understand that internal representations of experiences are organized around interpersonal relations.
   cc. Focus on interpretations of transference, defense mechanisms, and current symptoms of depression
dd. Help client to understand that interpersonal factors may contribute heavily
to his/her depressed mood
ee. Help client to understand that depression affects people's relationships and
these relationships further affect our mood
ff. Have client complete standardized outcome measures to track their progress in
treatment or their severity of symptoms (e.g., Beck Depression Inventory,
Hamilton Depression Inventory, Youth Outcome Questionnaire, etc.)

15. Please read the following statements that relate to your feelings about using new
types of therapy, interventions, or treatment. For the purpose of these questions,
“manualized therapy, treatment, or intervention” refers to any intervention that has
specific guidelines and/or components that are outlined in a manual and/or that are to
be followed in a structured or predetermined way. Indicate the extent to which you
agree with each item using the following scale 1=Not at all, 2=To a slight extent, 3=To a
moderate extent, 4=To a great extent, 5= To a very great extent

- a. I like to use new types of therapy/interventions to help my clients.
- b. I am willing to try new types of therapy/interventions even if I have to follow a
treatment manual.
- c. I know better than academic researchers how to care for my clients.
- d. I am willing to use new and different types of therapy/interventions developed
by researchers.
- e. Research based treatments/interventions are not clinically useful.
- f. Clinical experience is more important than using manualized
therapy/interventions.
- g. I would not use manualized therapy/interventions.
- h. I would try a new therapy/intervention even if it were very different from what I
am used to doing.

16. Indicate the extent to which you agree with each item in the statement below using the
following scale 1=not at all, 2=to a slight extent, 3=to a moderate extent, 3=to a great
extent, 5= to a very great extent

If you received training in a therapy or intervention that was new to you, how likely
would you be to adopt it if:

- a. It was intuitively appealing?
- b. It “made sense” to you?
- c. It was required by your supervisor?
- d. It was required by your agency/organization/practice?
- e. It was required by your state?
- f. It was being used by colleagues who were happy with it?
- g. You felt you had enough training to use it correctly?
17. Do you work with kids with oppositional or conduct issues in your equine therapy practice?
   a. Yes
   b. No

18. If you were to work with a child/adolescent client with oppositional or conduct issues in your equine therapy practice, how likely would you be to use the following techniques during a session? (1=not at all, 2=to a slight extent, 3=to a moderate extent, 4=to a great extent, 5=to a very great extent)
   a. Modeling/Imitation of appropriate behaviors
   b. Behavioral rehearsal of appropriate behaviors
   c. Involvement of the child’s parents in the treatment process
   d. Involvement of the child’s parents in therapy sessions
   e. Social skills training
   f. Anger management techniques
   g. Focus on improving interpersonal skills
   h. Focus on improving pro-social behavior
   i. Play therapy strategies (free-range play)
   j. Rewarding or praising desirable/positive behaviors
   k. Shaping of more appropriate behaviors
   l. Assignment of homework
   m. Place emphasis on clients strengths
   n. Focus on current thoughts, feelings, and behaviors
   o. Engage in role-play exercises
   p. Ignore or punish deviant/negative behaviors
   q. Address child’s social-cognitive distortions
   r. Problem-solving skills training
   s. Perspective-taking skills training
   t. Relaxation exercises (PMR, deep breathing, circular breathing, etc.)
   u. Imposing consequences for compliant and non-compliant in-session behavior
   v. Increase child’s methods of effectively dealing with his/her thoughts and feelings
   w. Encourage client to use self-statements to inhibit impulsive, problematic behavior
   x. Help child to gain greater self-awareness and understanding about his/her own actions
   y. Attempt to determine how problematic thoughts or behaviors may accidentally get "rewarded" within a young person's environment
   z. Work to increase the strength of the emotional ties between the child and his/her parents
   aa. Allow the child to talk openly about his/her feelings in order to gain new insights and perspectives
bb. Work with the child to pinpoint the emotions/feelings that may be maintaining or worsening their problem behavior
cc. Just allow the client to engage with the horses in any manner desired (i.e., free time with the horses).

19. In your opinion/experience, what do you think best explains how clients make changes during equine therapy? Please choose no more than three statements that you believe are most important in equine therapy.
   a. Use of therapeutic metaphors
   b. Opportunity for anthropomorphism (i.e., attributing human characteristics or reasoning skills to animals) and/or personification (i.e., giving human traits to non-living objects)
   c. The real or perceived risk of interacting with horses
   d. The novelty of working closely with horses
   e. The ability to actively engage in hands-on activities and experiences that relate to clients real life, rather than just talking about their experiences abstractly
   f. The creation of stressful and challenging situations, made possible through activities with horses, allows clients to navigate their skills and abilities in a “safe” therapeutic setting
   g. Results from in-session activities provide immediate feedback (positive and negative) to clients, which help them to understand the consequences of their actions
   h. The solution-oriented focus on clients’ strengths as opposed to focus on their problems and weaknesses.
   i. Other: please explain

20. In a broad sense, what do you think are the most important client benefits of equine therapy? Indicate your opinion of the extent of importance of each item using the following scale 1=no importance, 2=slight importance, 3=moderate importance, 4=great importance, 5=very great importance
   a. An increase in adaptive skills
   b. An increased sense of empowerment and heightened self-esteem/self-efficacy
   c. Decreased negative/maladaptive behaviors
   d. Improved communication (verbal and non-verbal)
   e. Development of more effective coping skills
   f. Increase in self-confidence
   g. Increased awareness of strengths and weaknesses
   h. An increased ability to manage emotions effectively
   i. An increase in interpersonal effectiveness
   j. Improved mental health
   k. Improved quality of life
   l. Heightened spiritual awareness
   m. Education/Psychoeducation
21. In your opinion/experience what are the biggest challenges to implementing equine therapy services? Indicate the level of challenge for each item using the following scale 1=no challenge, 2=slight challenge, 3=moderate challenge, 4=great challenge, 5=very great challenge
   a. Insurance reimbursements
   b. Lack of referrals from clients who are interested in this type of therapy method
   c. Lack of research on effectiveness of equine therapy
   d. Lack of support from the mental health community
   e. Lack of support for this type of service in your local community
   f. Cost of services to the client
   g. Cost of services to the provider
   h. Finding a setting to provide your services within
   i. Finding quality, trained staff for your organization
   j. Other: explain

22. Why do you believe horses are an important feature of therapy? Please rank the following choices in order of their importance (1st = most important). You may type your own responses and include them in your ranking.
   a. Their size introduces feelings of fear, intimidation, discomfort, etc. that can help bring about change for the client
   b. Horses can read/sense humans’ feelings and emotions, which they mirror back to clients. This process can be helpful in therapy
   c. Horses are intuitive animals
   d. Horses are magical creatures
   e. Horses are large and powerful animals, which helps clients to overcome fear and develop confidence
   f. Horses are social animals with many similarities to humans
   g. Horses provide vast opportunities for metaphorical learning
   h. Other:

23. Are there populations of people who you feel are not appropriate for equine therapy services?
   a. Yes
      i. If yes, (#24) please explain (free-form response)
   b. No
Instructions Part II: Please read and respond to the following questions using the specific instructions provided for each. Questions in this section refer to the location (agency, organization, practice) in which you work as an equine therapy service provider.

25. In what type of setting do you provide equine therapy services? (If more than one setting applies, please check the one setting in which you provide the most equine therapy services and answer all questions in this section [part II] based on that setting).
   a. Outpatient therapy program
   b. Inpatient therapy program
   c. Partial-Hospital/Day-Treatment program
   d. School/Educational setting
   e. Residential Treatment program
   f. Forensic/Correctional setting
   g. I own a horse farm and MHPs rent space from me
   h. Other: ______(fill in)

26. What type of equine therapy services are offered through your location? Please check all that apply.
   a. EAGALA-model EAP
   b. Non-EAGALA-model EAP
   c. Equine-Assisted Learning (EAL)
   d. Equine-Assisted Therapy (EAT)
   e. Equine Facilitated Therapy (EFT)
   f. Equine Facilitated Psychotherapy (EFP)
   g. Equine-Assisted Counseling (EAC)
   h. Equine Experiential Learning (EEL)
   i. Equine Facilitated Learning (EFL)
   j. Equine Facilitated Mental Health (EFMH)
   k. Equine-Assisted Mental Health (EAMH)
   l. Equine-Facilitated Growth and Learning (EFG/EFL)
   m. Therapeutic Riding
   n. Other: ______ (fill in)

27. How many staff do you have at your equine therapy location?
   a. Total # of MHPs: __
   b. Total # of EEs: __
   c. Total # of Support Staff (office staff, barn help): __
   d. Total # of Unpaid Workers (interns, students, volunteers): __
   e. Total # of ‘Other’ Staff: (Explain their role)
28. How many staff have the following educational backgrounds within your location? 
(Place a number in each row).
   a. BA/BS (Bachelor’s Degree) = ___#
   b. MA/MS (Master’s Degree) = ___#
   c. MSW (Master of Social Work) = ___#
   d. LCSW (Licensed Clinical Social Worker) = ___#
   e. LPC (Licensed Professional Counselor) = ___#
   f. MFT (Marriage and Family Therapist) = ___#
   g. LCDC (Licensed Chemical Dependency Counselor) = ___#
   h. PhD (Doctor of Philosophy) = ___#
   i. PsyD (Doctorate of Psychology Degree) = ___#
   j. EdD (Doctor of Education) = ___#
   k. HSPP (Health Service Provider in Psychology) = ___#
   l. MD/DO (Doctor of Medicine or Doctor of Osteopathy) = ___#
   m. LLP (Limited License in Psychology) = ___#
   n. TLLP (Temporary Limited License in Psychology) = ___#
   o. Other: = ___#

29. How many equine therapy services providers at your location hold the following 
    training certifications?
   a. EAGALA Certification (must have completed Part I & Part II to be considered 
      EAGALA Certified): MHPs= ___, ESS= ___, Other= ___
   b. EAGALA Advanced Certified: MHPs= ___, ESS= ___, Other= ___
   c. OK Corral Series Certification: MHPs= ___, ESS= ___, Other= ___
   d. Equine Facilitated Mental Health Association Certification: MHPs= ___, ESS= ___, Other= ___
   e. PATH International/NAHRA Certification: MHPs= ___, ESS= ___, Other= ___
   f. Other, Non-EAGALA Training Certification: MHPs= ___, ESS= ___, Other= ___

30. Who is present during a typical equine therapy session at your location?
   a. Always a Mental Health Professional AND an Equine Specialist
   b. Sometimes an MHP and an ES
   c. Only an MHP or an ES is present (one or the other)
   d. Other staff (type in answer)

31. What is the duration of most equine therapy sessions within your location? Please 
    choose the duration for each category.
   a. Individual Sessions (I do not offer individual sessions, 50-60 min, 60-75, 75-90, 
      2hrs, 2+)
   b. Group Sessions (I do not offer group sessions, 50-60 min, 60-75, 75-90, 2hrs, 
      2+)
   c. Family Sessions (I do not offer family sessions, 50-60 min, 60-75, 75-90, 
      2hrs, 2+)
32. On average, how many sessions do clients attend equine therapy for at your location?
   a. 1-5 sessions
   b. 5-10 sessions
   c. 10-15 sessions
   d. 15-20 sessions
   e. 20+ sessions
   f. Other: ___ (please describe)

33. How is payment for equine therapy services determined for the MHP and the ES staff at your location?
   a. MHPs and ESs each earn a specified percentage of the cost for each session
      i. If checked ask: MHPs and ESs earn equal or different fees?
   b. MHPs and ESs earn a flat-rate fee for each session
      i. If checked ask: MHPs and ESs earn equal or different fees?
   c. Other: ___ (please describe)

34. How many horses do you typically have in the arena during an equine therapy session at your location?
   a. 1 horse
   b. 2 horses
   c. 3 horses
   d. 3-5 horses
   e. 5+ horses
   f. Varied -depending on size of group
   g. One for each person attending the session
   h. Other: ___ (please explain)

35. How do you determine how many horses to place in the arena for an equine therapy session at your location? (free-form response)

36. Do you use full size or miniature horses in your equine therapy sessions at your location?
   a. Full
   b. Mini
   c. Both
   d. Whatever client prefers
   e. It depends- (Please explain response)

37. Do you use the same horses for a client during each equine therapy session or choose different horses at your location (Example of using the same horses for each client’s session: Every time Susie Smith (client) comes for a session, Bucky the Buckskin is in the arena and so is Clyde the Clydesdale, and Raja the Arabian).
   a. Same Horses
   b. Different Horses
38. What is the reasoning for this type of horse selection during an equine therapy session at your location?
   a. The agency/organization/practice only owns [#] horses, so we use what is available
   b. Horse selection is based on client’s preference
   c. Horse selection is based on availability of horses
   d. Horse selection is based on a rotation of horses ‘work schedules’
   e. Horse selection is based on horse personality characteristics
   f. Horse selection is based on client personality characteristics
   g. Other: ___ (please explain)

39. Do you teach horsemanship skills (e.g., proper grooming, how to care for a horse, how to saddle a horse properly) as part of equine therapy at your location?
   a. Yes
   b. No
   c. Yes, only if it fits with the clients treatment goals (e.g., teaching grooming techniques to a client with poor hygiene)

40. Overall, what percentage of the equine therapy services you provide involve ground work vs. riding?
   a. Ground Work= ___%
   b. Riding=____%
   i. *If anything but 0% for riding – Ask (#41): Is riding part of an EAGALA-model therapy session?
      1. Yes
      2. No

42. How do you determine when a client is ready to terminate equine therapy at your location Select up to three responses that are most applicable.
   a. He/She has met all established treatment goals
   b. He/She has made sufficient progress towards established treatment goals
   c. He/She tells me when they’re ready to end treatment
   d. I just know when the client is ready to terminate
   e. When the client’s funding runs out
   f. When the client has completed the outlined curriculum/treatment protocol/ or pre-determined number of sessions.
   g. When it is reasonably clear that the client will no longer benefit from equine therapy services
   h. When services are no longer necessary
   i. When there is reason to believe the client might be harmed by continued services
   j. Other:
43. Do you include a processing/debriefing component to equine therapy sessions at your location?
   a. Yes
      i. If yes (#44), What does your processing component include?
   b. No
      i. If no (#45), Do you include anything in addition to the activity(ies) in an equine therapy session?

46. From whom do you collect client progress data during equine therapy at your location? (check all that apply)
   a. We do not collect client progress data
   b. Client
   c. Parent/Guardian
   d. Teacher
   e. Caseworker
   f. Parole/Probation
   g. Courts
   h. Department of Child Services
   i. Other (please explain)

47. What measures do you use to track progress? (Free-form response)

48. Do you create an individualized treatment plan for every equine therapy client at your location?
   a. Yes
   b. No
   c. It Depends (please explain)

49. Do you collaborate with equine therapy clients to establish their treatment plan and goals at your location?
   a. Yes
   b. No
   c. It Depends (please explain)
50. How do you collect the following information from clients seeking equine therapy services at your location (choices: do not collect, collect by clinical interview, collect using pencil and paper survey).
   a. Psychological history
   b. Medical history
   c. Current medications
   d. Diagnosis (current and previous)
   e. Previous treatment history
   f. Experience with horses
   g. Current symptoms
   h. Presenting problem
   i. Goals for therapy
   j. Social/developmental history
   k. Educational background
   l. Employment history
   m. History of trauma, abuse, neglect or exposure to violence
   n. Substance use
   o. Risk for suicide, self-harm, and/or homicide
   p. Treatment Plan

51. Do you engage parents or other family members/caregivers of equine therapy clients in the treatment process at your location?
   a. Yes
      If yes (#52), How do you engage them?
      i. They complete assessments
      ii. They help establish treatment goals and plans
      iii. They are actively involved in therapy sessions
      iv. Other: please explain
   b. No

53. What type of assessments do you use with clients involved in equine therapy at your location? Please check all that apply.
   a. None
   b. Objective Personality
   c. Projective Personality
   d. Aptitude/Ability/Achievement/Intelligence/Educational Tests
   e. Behavioral Tests:
   f. Neuropsychological

54. Is there an assessment protocol that you follow to determine the type and duration of services needed for each equine therapy client at your location?
   a. Yes
      If yes (#55), please describe/explain
   b. No
56. Do you follow a manualized treatment for equine therapy services at your location? For the purpose of this question, “manualized therapy, treatment, or intervention” refers to any intervention that has specific guidelines and/or components that are outlined in a manual and/or that are to be followed in a structured or predetermined way.
   a. Yes
      If yes, (#57) Is it published or self-developed?
         a. Yes
         b. No
   (58) Does staff receive training in the curriculum?
      a. Yes
      b. No
   (59) Are there fidelity checks to make sure staff is adhering to curriculum?
      a. Yes
      b. No

b. No

60. What is the sequence of activities in a typical equine therapy session at your location? (e.g., warm up, activity, processing, wrap, etc.) (free-form response).

61. As a whole, how often does your location provide equine therapy services to the following client populations? (choices: 75-100% of the time, 50-75%, 25-50%, less than 25%, never)
   a. Children (Individual – Group)
   b. Adolescents (Individual – Group)
   c. Adults (Individual – Groups)
   d. Older Adults (Individual – Group)

62. Considering all the equine therapy clients your location serves, please provide an estimate of what percentage of your equine therapy clients are male and female.
   a. Male = ____%
   b. Female = ____%
63. Considering all the equine therapy clients your location serves, how often is equine therapy provided to the following client populations: (choices: frequently, often, sometimes, rarely, never)
   a. Clients with eating disorders
   b. Clients with ODD/CD/ADHD
   c. Clients with depression
   d. Clients with substance abuse issues
   e. Clients with anxiety disorders
   f. Clients with Autism, Asperger’s, or other ASD or MR/DD diagnoses
   g. Clients with attachment concerns
   h. Clients with PTSD or other trauma related issues
   i. Clients with personality disorders (Axis II diagnoses)
   j. Clients with learning difficulties
   k. Clients who are physically challenged
   l. Veterans
   m. At-Risk Youth
   n. Forensic/Court Referred
   o. Other:

64. Considering all the equine therapy clients your location serves, what percentage of your clients are funded from the following sources?
   a. Private Insurance = __%
   b. Public Aid (Medicaid/Medicare) = __%
   c. Veterans Benefits = __%
   d. Self-Pay= __%
   e. Grant-Funded= __%
   f. Other public (3rd party) funding = __%
   g. Donations from community= __%
   h. Other: __ (please explain)

65. Considering all the equine therapy clients your location serves, how do your equine therapy clients learn of/hear about your services? Please rank the following list from largest referral source to smallest referral source.
   a. Referral from schools
   b. Referral from courts
   c. Referral from other mental health professionals
   d. Referral from a church/religious group
   e. Self-Advertising/Marketing (Specify: Online, Phonebook, Newspaper, Magazine, Flyers, Billboard, etc.)
   f. Other (please specify)
Appendix B

Phase I Invitation/Recruitment Letter
Dear Equine Assisted Therapy Professional:

You are invited to participate in a research project entitled “Equine-Assisted Therapy: A Descriptive Study” designed to examine the program operations and treatment practices of individuals and organizations providing equine therapy services nationwide. Your contact information was extracted from publicly accessible sources used to locate equine therapy service providers (e.g., online provider directories). The study is being conducted by Dr. Amy Naugle, PhD and Erica Jex Gergely, M.A. from Western Michigan University, Department of Psychology. This research is being conducted as part of the doctoral dissertation requirements for Erica Jex Gergely, M.A.

The study utilizes an online survey comprised of several closed and open-ended questions and will take you approximately 35 minutes to complete. Your replies will be completely anonymous, so do not put your name anywhere within the survey. You may choose to not answer any question and simply leave the response blank. If you choose not to participate in this survey, please discard this invitation. If you choose to participate, please visit https://www.surveymonkey.com/s/EquineTherapy and follow the instructions provided. Submitting the survey indicates your consent for use of the answers you supply. While there are no known risks or direct benefits to participants, the information you provide will add to the existing database of knowledge on equine therapy programming nationwide. As a small gesture of appreciation for your participation, you may choose to be entered into a drawing for a chance to win one of two gift cards in the amount of $50. If you have any questions, you may contact Dr. Amy Naugle at 269-387-4726, Erica Jex Gergely, M.A. at 716-523-1359, the Human Subjects Institutional Review Board (269-387-8239) or the vice president for research (269-387-8298).

This letter of invitation has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. You should not participate in this project if the stamped date is more than one year old.

*Attached to this e-mail is an electronic copy of the Human Subjects Institutional Review Board (HSIRB) approved consent document for your review.

Thank You for Your Support,

____________________  ____________________
Amy Naugle, PhD      Erica Jex Gergely, MA
Principal Investigator  Student Investigator
Western Michigan University  Western Michigan University
Appendix C

Follow-Up Invitation Letter
Dear Equine Assisted Therapy Professional:

Several weeks ago you were contacted with an invitation to participate in a research project entitled “Equine-Assisted Therapy: A Descriptive Study” designed to examine the program operations and treatment practices of individuals and organizations providing equine therapy services nationwide. I would like to take another opportunity to invite you to partake in this study, which is being conducted by Dr. Amy Naugle, PhD and Erica Jex Gergely, M.A. from Western Michigan University, Department of Psychology. Your contact information was extracted from publicly accessible sources used to locate equine therapy service providers (e.g., online provider directories). This research is being conducted as part of the doctoral dissertation requirements for Erica Jex Gergely, M.A.

The study utilizes an online survey comprised of several closed and open-ended questions and will take you approximately 35 minutes to complete. Your replies will be completely anonymous, so we ask that you do not put your name anywhere within the survey. You may choose to not answer any question and simply leave the response blank. If you choose not to participate in this survey, please discard this invitation. If you choose to participate, please visit https://www.surveymonkey.com/s/EquineTherapy and follow the instructions provided. Submitting the survey indicates your consent for use of the answers you supply. While there are no known risks or direct benefits to participants, the information you provide will add to the existing database of knowledge on equine therapy programming nationwide. As a small gesture of appreciation for your participation, you may choose to be entered into a drawing for a chance to win one of two gift cards in the amount of $50. If you have any questions, you may contact Dr. Amy Naugle at 269-387-4726, Erica Jex Gergely, M.A. at 716-523-1359, the Human Subjects Institutional Review Board (269-387-8239) or the vice president for research (269-387-8298).

This letter has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. You should not participate in this project if the stamped date is more than one year old.

Thank You Again For Your Support,

____________________
Amy Naugle, PhD
Principal Investigator
Western Michigan University

____________________
Erica Jex Gergely, MA
Student Investigator
Western Michigan University
Appendix D

Phase II Invitation/Recruitment Letter
Dear Equine Assisted Therapy Professional:

You are invited to participate in Phase II of the research project entitled “Equine-Assisted Therapy: A Descriptive Study” designed to assess aspects of equine therapy implementation among individuals and organizations providing equine therapy services nationwide. Your contact information was extracted from the information you provided within Phase I of this study, which involved a web based survey. The study is being conducted by Dr. Amy Naugle, PhD and Erica Jex Gergely, M.A. from Western Michigan University, Department of Psychology. This research is being conducted as part of the doctoral dissertation requirements for Erica Jex Gergely, M.A.

Participants will be asked to audio-record a few equine assisted therapy sessions (using equipment provided by the researcher if needed) and to rate aspects of their intervention implementation, using the Equine Assisted Psychotherapy –Treatment Integrity Checklist (EAP-TIC), following these audio recorded sessions. Participants will then be asked to mail the audio recording (captured on an SD card provided by the researcher), the corresponding EAP-TIC form, and the corresponding client consent document (provided) in a secured, self-addressed, stamped envelope back to the researcher.

While there are no known risks or direct benefits to participants, the information you provide will add to the existing database of knowledge on equine therapy implementation nationwide. In addition, completing the EAP-TIC may help participants evaluate and assess aspects of their equine therapy implementation. As a small gesture of appreciation for participation in this phase of the study, all participants who successfully engage in Phase II will be offered a copy of a brief evaluative report based on the findings of this study. Further, participants who successfully engage in Phase II will be offered the opportunity to enter a drawing for an EAGALA gift certificate in the amount of $100.

If you have any questions, you may contact Dr. Amy Naugle at 269-387-4726, Erica Jex Gergely, M.A. at 716-523-1359, the Human Subjects Institutional Review Board (269-387-8239) or the vice president for research (269-387-8298). This consent document has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. You should not participate in this project if the stamped date is more than one year old. Attached to this e-mail is an electronic copy of the Human Subjects Institutional Review Board (HSIRB) approved consent document for your review.

Thank You for Your Support,

____________________
Amy Naugle, PhD
Principal Investigator
Western Michigan University

____________________
Erica Jex Gergely, MA
Student Investigator
Western Michigan University
Appendix E

Phase II Participant Consent Document
You have been invited to participate in Phase II of a research project titled “Equine-Assisted Therapy: A Descriptive Study.” This study is being conducted by Western Michigan University’s Dr. Amy Naugle and Erica Jex Gergely, and will serve as Erica’s doctoral dissertation project.

What are we trying to find out in this study?
The study is designed to measure aspects of equine therapy implementation among professionals nationwide.

Who can participate in this study?
Any EAGALA-model equine therapy service provider within the United States is eligible to participate in this study. No additional criteria are necessary in order to participate.

Where will this study take place?
Phase II of this study, which involves the audio-recording of equine therapy sessions, will take place in the participants own treatment location.

What is the time commitment for participating in this study and what will participants be asked to do?
As a participant in Phase II of this study, you are being asked to perform your usual equine therapy facilitation duties (i.e., mental health profession or equine specialist) in accordance with the standards of practice set forth by your agency/organization/practice. You will also be asked to execute some additional data collection procedures during and after each session for the purposes of this research study. Specifically, you will be asked to audio-record equine therapy sessions and, once the session has ended, to complete a checklist that asks you to document various aspects of your intervention implementation.

What information is being measured during the study?
The post-session checklists you will be asked to complete measure various aspects of your intervention implementation and aspects of the overall treatment process. Audio-recordings serve as additional data to supplement the self-reported information captured in the post-session checklists.
What are the risks of participating in this study and how will these risks be minimized?
There are no known risks, above and beyond those inherent in equine therapy, to participating in this study. As a service provider and participant of this study, you are being asked to continue your standard practices in accordance with your agency/organization/practice’s policies and procedures, and in addition, to audio-record therapy sessions and to spend approximately 5 minutes after those sessions completing a research-oriented checklist, which may be experienced as a burden on your time.

What are the benefits of participating in this study?
There are no personal benefits for participating in this study beyond the potential benefits associated with facilitating equine assisted psychotherapy. However, completing the research-checklist may help participants to evaluate aspects of their EAP implementation.

Are there any costs associated with participating in this study?
Other than the time commitment necessary to audio-record equine therapy sessions and to complete post-session checklists, there are no other known costs associated with participating in this study.

Is there any compensation for participating in this study?
There is no compensation offered to treatment providers above and beyond their fees paid by their equine therapy agency/organization/practice for participating in the study. However, as a small gesture of appreciation for participation in this phase of the study, all participants who successfully engage in Phase II will be offered a copy of a brief evaluative report based on the findings of this study. Further, participants who successfully engage in Phase II will be offered the opportunity to enter a drawing for an EAGALA gift certificate in the amount of $100.

Who will have access to the information collected during this study?
All of the information collected from you during this study will only be accessed by those involved in the research (i.e., primary and student investigator, research assistants).

What if you want to stop participating in this study?
You may choose not to participate in this research study. You may also choose to withdraw your consent or discontinue participation in the research at any time. Upon withdrawal, you would not be asked to complete any additional data collection procedures.

Should you have any questions prior to or during the study, you can contact the primary investigator, Dr. Amy Naugle at 269-387-4726 or at amy.naugle@wmich.edu, or Erica Jex Gergely at 716-523-1359 or at erica.l.jex@wmich.edu. You may also contact the Chair, Human Subjects Institutional Review Board at 269-387-8293 or the Vice President for Research at 269-387-8298 if questions arise during the course of the study.
This consent document has been approved for use for one year by the Human Subjects Institutional Review Board (HSIRB) as indicated by the stamped date and signature of the board chair in the upper right corner. Do not participate in this study if the stamped date is older than one year.

I have read this informed consent document. The risks and benefits have been explained to me. I agree to take part in this study.

___________________________________  ____________
Participant’s Signature  Date
Appendix F

Phase II Client & Parent/Guardian
Permission to Audio Record Form
Dear Equine Therapy Client:

Your equine therapy service provider is participating in a research study titled, “Equine-Assisted Psychotherapy: A Descriptive Study” that involves audio-recording treatment sessions. The study is designed to measure aspects of equine therapy intervention implementation among professionals nationwide.

As an individual seeking equine therapy services from a participant in this study, you are being asked to allow your treatment provider to audio-record one or more of the equine therapy sessions you partake in. There are no other requests of you for the purposes of this study and your identity will not be revealed in any of the data being collected.

You may choose not to allow the service provider to audio-record your sessions and your equine therapy services will not be affected in any way. You may also choose to withdraw your permission to audio-record sessions at any time without being affected in any way. If you want to withdraw your permission, you would just need to inform your equine therapy service provider. After informing your equine therapy service provider, your sessions will no longer be audio-recorded for purposes related to this study.

______________________________________________________________________________

I have reviewed the above information with my client. The nature of the audio-recording for research purposes has been explained to him/her and he/she has provided verbal permission for the recording of sessions. By signing below I am indicating that I have obtained verbal permission from my equine therapy client.

___________________________________ ________________________________
Service Provider’s Signature Date

If client is a minor, please check the box and sign below to indicate that permission to audio-record sessions was also granted by his/her parent or guardian.

☐ Client is under the age of 18, therefore verbal permission was obtained from his/her parent or guardian in addition to obtaining assent from minor.

___________________________________ ________________________________
Service Provider’s Signature Date
Appendix G

Equine Assisted Psychotherapy – Treatment Integrity Checklist (EAP-TIC)
## Equine Assisted Psychotherapy Treatment Integrity Checklist

Instructions: Using the scales below, please indicate the rate with which the following EAP facilitator-related behaviors occurred during the session.

<table>
<thead>
<tr>
<th>Use of Metaphors: one thing conceived as representing another</th>
<th>Did Not Occur</th>
<th>Occurred 1 time</th>
<th>Occurred 2-3 times</th>
<th>Occurred 4+ times</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Include: Directive (natural, client-led) &amp; Non-Directive (formal, goal-led)</td>
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<td>- Ex: The horse represents client’s parents; The horse ‘jump’ represents an obstacle in client’s life</td>
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<thead>
<tr>
<th>Use of Projection: attributing one’s thoughts, feelings, behaviors, and experiences onto another person, animal, or object</th>
<th>Did Not Occur</th>
<th>Occurred 1 time</th>
<th>Occurred 2-3 times</th>
<th>Occurred 4+ times</th>
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<tbody>
<tr>
<td>- Ex: Asking client, “What might the horse be thinking?” or “How might you feel if you were the horse right now?”</td>
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<td>- Ex: Client being frustrated with the horse; Client defensiveness; Extreme emotional reactions from client</td>
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<thead>
<tr>
<th>Use of Socratic Questioning: asking strategic questions to understand client’s thoughts, feelings, behaviors, perspectives, etc. and to help them discover their own solutions/answers to problems</th>
<th>Did Not Occur</th>
<th>Occurred 1 time</th>
<th>Occurred 2-3 times</th>
<th>Occurred 4+ times</th>
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<td>- Ex: Asking client to define problem; Examining client’s evidence for thoughts; Assessing consequence of specific behaviors, thoughts, attitudes, perspectives; Assisting client in the identification of thoughts, feelings, assumptions</td>
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<tr>
<th>Use of Reflective Listening: summarizing, mirroring, restating, and/or clarifying what the client has said</th>
<th>Did Not Occur</th>
<th>Occurred 1 time</th>
<th>Occurred 2-3 times</th>
<th>Occurred 4+ times</th>
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<tr>
<td>Ex: Saying to client, “If I’m hearing you correctly, you said that you think the horse is angry at you?” or “So, you feel like a failure?”</td>
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<tr>
<th>Use of Clean/Objective Language: non-judgmental, non-influential, non-subjective language toward client</th>
<th>Did Not Occur</th>
<th>Occurred 1 time</th>
<th>Occurred 2-3 times</th>
<th>Occurred 4+ times</th>
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<td>- Ex: Saying to client, “Tell me about the horse now” (as opposed to, “Doesn’t the horse seem scared right now?”)</td>
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<tr>
<th>Encouragement of Skills Generalization: encouraging and assisting in the transfer of in-session skills to real life situations</th>
<th>Did Not Occur</th>
<th>Occurred 1 time</th>
<th>Occurred 2-3 times</th>
<th>Occurred 4+ times</th>
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<tr>
<td>Ex: Asking client, “When in your life might you use these awareness skills?” “How does this relate/apply to you and your daily life?”</td>
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<tr>
<th>Focus on Client Strengths: highlighting client’s strengths, effective use of skills, positive behaviors, etc.</th>
<th>Did Not Occur</th>
<th>Occurred 1 time</th>
<th>Occurred 2-3 times</th>
<th>Occurred 4+ times</th>
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<td>Ex: Telling client, “You did a great job communicating your needs to the horse.” or “You used your assertiveness skills well in that activity.”</td>
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<td>Tolerance of Failures, Frustrations, Challenges, Obstacles: allowing client to be unsuccessful, frustrated, or challenged by a task without rescuing or problem-solving for them</td>
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<td>Ex: Not interfering when client is unable to get the horse over a jump after many trials or when frustrated at being unable to succeed in a task.</td>
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| Incorporation of Treatment Goals or Presenting Problem into Activity: deliberately designing an activity with client’s treatment goals or presenting problem in mind Ex: Substance abusing client asked to complete activity where feed & water are purposefully available to distract/tempt horse during task. |
|---|---|---|---|
| Client observes horse’s response to ‘temptations’ and ‘triggers’ that are similar to client’s reaction to drugs/alcohol. |

| Acknowledgment of Shifts: observable changes within client or horse(s) behaviors |
|---|---|---|---|
| Ex: Saying to client, “I noticed the horses were close to you and now they’re far away” or “At first you were not able to get near the horse, now you are putting the halter around its head.” |

| Acknowledgment of Patterns: any behavior of the client or the horse(s) that occurs more than 3 times |
|---|---|---|---|
| Ex: The horses running around in circles; The client/horse stepping on the lead rope |

| Acknowledgment of Uniqueness: a behavior of the client or horse(s) that is out of the ordinary/unusual |
|---|---|---|---|
| Ex: Horse(s) kick up/buck; An unemotional client becomes unusually emotional |

| Acknowledgment of Discrepancies: when the client’s verbal behavior does not match his/her non-verbal behavior |
|---|---|---|---|
| Ex: Client says he/she doesn’t want to do an activity but walks toward the horse and appears engaged; Client says he/she dislikes the horses but is constantly petting them; Client says he/she is not angry, but is seen throwing items and stomping around arena in an angry manner. |

| Interfering with Client’s Growth & Learning: Treatment staff engaging in behaviors that interfere with client’s growth and learning opportunities |
|---|---|---|---|
| Ex: Rescuing client from failure, challenges, frustrations; Problem-solving for client; Solution-generating for client; Controlling client Ex: Saying to client, “This is the way you should have done the activity.” or “Next time, you should try to tie the halter tighter so it doesn’t fall off.” |

<p>| Criticizing, Judging, Blaming, or Being Confrontational with the Client: using judgmental, confrontational or harsh language toward client |
|---|---|---|---|
| Ex: Saying to client, “The activity was a failure because you didn’t listen well” or “Why would you have done such a foolish thing?” |</p>
<table>
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<tr>
<th>Use of Non-Clean, Subjective Language: using language that is biased, leading, or based on one perspective alone Ex: Saying to client, “The horse just ran away because he was scared” or “You were very frustrated by that activity.”</th>
<th>Did Not Occur</th>
<th>Occurred 1 time</th>
<th>Occurred 2-3 times</th>
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<td>Focus on Product or Outcome of Activity (Rather Than Process): attending to whether or not the client was successful with an activity or followed specific instructions correctly, rather than the process that he/she engaged in during the activity (the growth &amp; learning that occurred) Ex: Saying to client, “You were supposed to get the horse over the jump but the pole fell, so you didn’t actually do it right” or “The instructions stated to have the horse circle you 3 times, not 2.”</td>
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<td>Focus on Horsemanship or Riding: instructing client about horse riding, horse ownership, horse care in a manner unrelated to treatment goals Ex: Training client in how to properly saddle a horse for riding or placing a client on the horse’s back  *Do Not Include: Information about horse behavior or horse care related to client’s goals (grooming horse = educating client in self-care/hygiene)</td>
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Indicate your subjective impression of how much the client ___________________________ during the session based on your observation of his/her in-session behavior.

<table>
<thead>
<tr>
<th>Little to None</th>
<th>Some</th>
<th>Much</th>
<th>A Lot</th>
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<td>Engaged in the treatment process (e.g., complied with treatment activity, actively participated in processing, effortful behavior, etc.)</td>
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<td>Exhibited/Expressed oppositional behavior (e.g., verbal and physical aggression, non-compliance, anger, acting out, etc.)</td>
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<td>Successfully generalized experiences (e.g., related a skill, event, activity, or occurrence from in-session to general life or vice versa)</td>
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<td>Benefitted from treatment (e.g., overall how meaningful was this session to the client’s treatment goals)</td>
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Appendix H

Human Subjects Institutional Review Board Protocol Clearance Letter
Date: December 5, 2011

To: Amy Naugle, Principal Investigator
    Erica Gergely, Student Investigator

From: Victoria Janson, Interim Chair

Re: HSIRB Project Number 11-12-04

This letter will serve as confirmation that your research project titled “Equine Assisted Therapy: A Descriptive Study” has been approved under the expedited category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: December 5, 2012