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Horses in Therapy: The Practice of Equine Facilitated Psychotherapy

Mandi J. Turner
University of Denver

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HORSES IN THERAPY: THE PRACTICE OF EQUINE FACILITATED PSYCHOTHERAPY


A DOCTORAL PAPER
PRESENTED TO THE FACULTY OF THE
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DOCTOR OF PSYCHOLOGY

BY
MANDI J TURNER
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APPROVED:


Laura Meyer, Ph.D., Chair


Lynett Henderson-Metzger, Psy.D., M.D., Committee Member


Justin Lincoln, Psy.D., Committee Member

Abstract

Horses are being used in psychotherapy at increasing rates despite a lack of evidence establishing efficacy of the practice (Anestis, Anestis, Zawilinski, Hopkins, & Lilienfeld, 2013; Selby & Smith-Osborne, 2013). Without common and consistent practices based on a working theory of how Equine Facilitated Psychotherapy (EFP) creates change, it is unknown how varied the practice is across the United States (Anestis et al., 2013). A lack of studies establishing efficacy leaves providers to determine effectiveness based on anecdotal evidence that may be at risk for bias (Lilienfeld, Ritschel, Lynn, Cautin, & Lutzman, 2014). The American Psychological Association (APA) provides recommended best practices for clinical decision-making, which bases a large portion of efficacy for a treatment on randomized controlled trials (APA Taskforce on Evidence-Based Practice, 2006), currently non-existent within the EFP literature (Anestis et al., 2013). For the current study, EFP providers were surveyed to assess their knowledge and implementation of evidence-based practices in psychology within their EFP work. Providers were primarily White/Caucasian females from counseling or social work backgrounds with training in the EAGALA model as well as other psychological treatment backgrounds. Results indicated that EFP providers treat individuals with a variety of syndromes, with trauma, mood disorders, and anxiety disorders primarily reported. Our sample indicated adherence to basic EBPP by many of the providers, including having a broad base of experience from which to draw information, combining standardized protocols with interventions specifically chosen for individual client needs, assessing client progress with a combination of quantitative and qualitative measures, and utilizing diagnostic information to inform treatment planning.

Keywords: equine, psychotherapy, EFP, evidence-based practice in psychology, EBPP

Horses in Therapy: The practice of Equine Facilitated Psychotherapy

Equine Facilitated Psychotherapy (EFP) is an experiential therapy that incorporates horses into the therapeutic team for the specific purpose of treating a mental, emotional, or social impairment (Bachi, Terkel, & Teichman, 2011; Hallberg, 2008). EFP is one term to describe psychotherapy in the presence of a horse, which in varying practices and institutions may be termed Equine Assisted Psychotherapy, Equine-Assisted Mental Health, Equine Assisted Experiential Therapy, Gestalt Equine Psychotherapy, Equine-Facilitated Body and Emotion-Oriented Psychotherapy, Trauma-Focused Equine Assisted Psychotherapy, and Equine Assisted Counseling, among others, depending upon the certifying organization, its differing views on the role the horse and therapist plays in session, and the focus of treatment (Equine Assisted Growth and Learning Association [EAGALA], n. d.; Equine Psychotherapy Institute, n. d.; Gestalt Equine Institute of the Rockies, n. d.; Human-Equine Alliance for Learning, n. d.; Human-Equine Relational Development Institute, n.d.; Institute for Human-Animal Interaction, n. d.; Johansen, Arfwedson Wang, Binder, & Malt, 2014; Klontz, Bivens, Leinart, & Klontz, 2007; Natural Lifemanship, n. d.; Professional Association of Therapeutic Horsemanship International [PATH], n. d.; Trotter, 2012). It is a treatment currently being used across the United States and other countries for a variety of psychological and behavioral problems despite a lack of quality evidence-based support for its effectiveness (Selby & Smith-Osborne, 2013).

In a perfect world, clinicians would draw conclusions about how well a treatment works from a variety of research studies. Authors in this area generally agree that the literature supporting the efficacy of EFP and other Animal Assisted Therapies (AAT) is insufficient (Fine, 2015; Johansen et al., 2014) and studies that do exist provide only low to moderate quality of scientific evidence (Latella & Abrams, 2015; Selby & Smith-Osborne, 2013). The studies

looking at the efficacy of this treatment in clinical practice fail to adequately rule out non-treatment factors that could explain some of the positive changes in treatment outcomes (Anestis et al., 2013). Despite the lack of quality research support, practice appears to be thriving, which is a “reflection of the common finding that participant and staff perceptions [of efficacy] sometimes exceed statistical evidence” (Selby & Smith-Osborne, 2013, p. 428).

Anecdotal stories about the benefits of EFP abound. For example, EFP is often suggested as a treatment superior to standard talk therapy, especially for individuals who may not do well in those settings (Bachi et al., 2011; Johansen et al., 2014; Mueller & McCullough, 2017; Trotter, Chandler, Goodwin-Bond, & Casey, 2008;), without empirical support available in the literature (Cumella, 2003; Herzog, 2011). Without access to quality evidence-based research, providers appear to be basing judgments of efficacy on “clinical experience, supported by noncontrolled studies” (Johansen et al., 2014, p. 327) and on anecdotal evidence, which may leave observations of client improvement vulnerable to biases (Herzog, 2011; Lilienfeld et al., 2014).

Both qualitative and quantitative studies, despite their shortcomings in establishing adequate evidence of efficacy, show promise (Selby & Smith-Osborne, 2013). The criticisms of EFP are not an indication of an invalidated treatment, but rather an under-validated treatment (Lilienfeld et al., 2014). The American Psychological Association (APA Presidential Task Force on Evidence Based Practice, 2006) created guidelines to provide support for the use of treatments that are under-funded and under-researched. Termed Evidence-Based Practice in Psychology (EBPP), these guidelines allow clinicians to pull information needed for clinical decisions from a variety of sources when efficacy research is scarce (APA Presidential Task Force on Evidence Based Practice, 2006). Following these recommendations reduces the risk of

bias when making determinations about whether a client is benefitting from the treatment (Lilienfeld et al., 2014). Considering the preponderance of anecdotal evidence in this field (Herzog, 2011), this paper will determine how closely EFP providers adhere to EBPP guidelines in clinical practice, which may give more credence to their judgments of the effectiveness of this treatment.

Literature Review

Animal and Equine Therapies

Animal Assisted Interventions. Animal Assisted Interventions (AAI) include the presence of an animal for the therapeutic benefit of a human in health, education, or human service settings (International Association of Human-Animal Interactions Organization [IAHAIO], 2014). A core assumption of AAIs is that humans are relational and that they need and benefit from interaction with all beings, not just with other humans (Chandler, 2005). They can be further broken down into Animal Assisted Education, Animal Assisted Activities, and Animal Assisted Therapies based on the goals of the interventions and the level of expertise of the provider (IAHAIO, 2014).

In Animal Assisted Therapies (AAT) especially, adding an animal into the therapeutic relationship is meant to supplement the therapeutic process with specific, targeted benefits, which may not be easily accomplished by the provider alone (O'Callaghan & Chandler, 2011). Trotter (2012) reviewed 10 mental health applications of AATs, the results of which indicated that providers believe animals can provide a safer attachment figure for certain clients than the therapist, create opportunities for physical touch that are not appropriate between client and therapist, and facilitate conversations that otherwise would be difficult. Research on human-animal bonds with companion animals shows benefits to humans in physical and psychological

ways which shows promise for use in therapy settings but is still unsubstantiated (Crawford, Worsham, & Swinehart, 2006).

Equine-related therapeutic interventions. The addition of a horse to various treatment modalities is reported to have benefits in physical, mental and emotional health (Hallberg, 2008). Hippotherapy, therapeutic riding, adaptive riding, therapeutic horsemanship, equine facilitated education (EFE), and equine facilitated learning (EFL) are AAIs that involve the horse as a part of a rehabilitation regimen (American Hippotherapy Association [AHA], 2017; Hallberg, 2008; PATH, n. d.). Hippotherapy, an AAT, is used for physical, occupational, and/or speech therapies (AHA, 2017). Therapeutic riding, adaptive riding, and therapeutic horsemanship are considered Animal Assisted Activities and are conducted by specially trained horse professionals primarily for individuals with physical, developmental, or cognitive impairment (PATH, n. d.). EFL and EFE fall under Animal Assisted Education as they are focused on specific learning goals and are conducted by a professional in horsemanship, education or mental health (Hallberg, 2008). Unlike EFP, EFL is oriented toward the acquisition and practice of targeted skills with little focus on processing personal insights (Cameron & Robey, 2013).

Equine Facilitated Psychotherapy. For the purposes of this study, the term EFP will be used to denote an AAT delivered by a licensed psychotherapist that incorporates horses into the therapeutic team for the specific purpose of treating a mental, emotional, or social impairment (Bachi et al., 2011; Hallberg, 2008). EFP can be conducted individually, in groups, or with families or couples (Hallberg, 2008). A therapist can be dually trained in psychotherapy and horsemanship or work alongside a horse specialist to ensure safety of participants (PATH, n. d.). EFP is an experiential therapy that involves interaction with the horse through observing, grooming, handling, and sometimes riding, among other activities (Hallberg, 2008). Clients act

out behaviors that are problematic in their everyday lives, which often elicits a negative response from the horse (Schultz, Remick-Barlow, & Robbins, 2007). The response of the horse elucidates the behavior of the client and allows the provider and client to see immediately what effect the client is having on the horse, which is often referred to as a “biofeedback-like process” (Hallberg, 2008, p. 277). The provider utilizes traditional counseling techniques during these interactions to bring about insight and change (Trotter, 2012).

Bringing a horse into the therapeutic team is thought to have specific benefits for clients. Clients may increase their self-esteem and self-awareness, which is crucial for interacting with other humans (Trotter et al., 2008). Clients may develop a sense of power and confidence through practicing assertive control over a large and powerful being (Trotter, 2014). Bachi et al. (2011) point out the ability to use touch as a tool, while grooming and riding the horse, which clients can ethically use to create and strengthen their bond with the horse.

Qualitative studies of EFP show parallels in clients’ descriptions of the equine-human bond to qualities of the therapeutic alliance (Yorke, Adams, & Coady, 2008). The facilitative role of the horse is grounded in the way that clients describe them as non-judgmental creatures, which allows clients to feel more open in processing thoughts and/or emotions in their presence (Hallberg, 2008; Lee, 2017). For those recovering from trauma, the equine-human bond has the potential to provide a foundation of “safety and development of trust, self-esteem, and self-efficacy” that may be difficult to achieve through human connection (Yorke et al., 2008, p. 17).

How EFP is used. The literature on EFP lists several broad uses, but due to a lack of best practice research and sufficient focus on any specific syndromes or symptoms, there is little known about how EFP is used in clinical practice. Based on quantitative and qualitative studies, as well as conceptual papers, EFP has been used with anxiety (Thiel, 2014), posttraumatic stress

and trauma-related disorders (Abrams, 2013; Earles, Vernon, & Yetz, 2015; Kemp, Signal, Botros, Taylor, & Prentice, 2014; Schultz et al., 2007), eating disorders (DeZutti, 2013), and addiction (Stiltner, 2013). A meta-analysis of published findings (as cited in Selby & Smith-Osborne, 2013) included the following outcome measures: Depression and wellness scores (Bowers & MacDonald, 2001), relational adjustment/satisfaction in couples (Russell-Martin, 2006), symptom severity and psychological well-being (Klontz et al., 2007), and depression, dissociative experiences, and client-reported outcomes in complex trauma (Shambo, Seely, & Vonderfecht, 2010). Studies reviewed by Anestis et al. (2013), include focus on global assessment of functioning scores (Schultz et al., 2007), self-control, self-image, and trust (Bachi et al., 2011), behavioral problems (Trotter et al., 2008), and eating disorder and mood symptoms (Lutter & Smith-Osborne, 2011). Many of the studies listed above show promise in improvement of outcomes, establishing some evidence for effectiveness and acceptance of the treatment in practice, but lack sufficient control to rule out validity errors for determining that EFP is the cause of the improved outcomes (Anestis et al., 2013).

Criticisms of EFP. Aside from the lack of evidence for efficacy reviewed above, several other concerns exist. First, no single theoretical basis can be found in the literature regarding the therapeutic effects of horses, or of animals in general (Anestis et al., 2013; Kruger & Serpell, 2006). There is some disagreement as to whether EFP would require its own theoretical basis when used primarily as an adjunct therapy to enhance the psychotherapy process and not as an independent treatment (Trotter, 2012). It is unclear, however, how often providers use or present EFP as an independent treatment to consumers in practice (Anestis et al., 2013) and more information regarding the implementation of EFP and other AAIs would be beneficial, whether used as primary or adjunct treatments (Fine, Tedeschi, & Elvove, 2015). Second, EFP is not well

known or understood by the greater mental health community; studies lack clear descriptions of what constitutes an EFP session, there are no formalized treatment manuals used across studies, and multiple training procedures and/or certifications exist for providers, each with their own requirements and standards (Anestis et al., 2013; Fine, 2015; see Appendix D for a list of certification programs and requirements). Third, different forms of equine interventions are often confused or combined as the same treatments in the literature and as mentioned above, several labels are used for possibly the same treatment, both of which increase the mystery of what EFP is (Anestis et al., 2013; Lentini & Knox, 2009). And last, EFP and other AAT providers rely heavily upon anecdotal evidence, which raises doubts in the greater scientific community about the legitimacy and acceptance of the treatment as more focus is placed on empirically validated treatments and procedures (Fine, 2015). Anecdotal evidence, especially based on personal testimony, is prone to bias as those who are treated successfully tend to be more likely to share their stories with the provider, and providers are often more attuned to those with positive results (Irwig, Irwig, Trevena, & Sweet, 2007; Lilienfeld et al., 2014). Considering the scarcity of empirical evidence of a cause and effect relationship between EFP and treatment outcomes, the lack of understanding of the treatment by outsiders, the array of equine-related activities being offered to the public, and the abundance of anecdotal claims, concern for the consumer seeking services seems valid (Anestis et al., 2013).

What makes EFP difficult to study? Solid empirically-derived evidence for efficacy requires a research design featuring either random assignment of participants to different treatment or control conditions, or less preferred, non-random naturalistic sampling with ample descriptors by which to compare the research group to those in other studies (Luborsky & Fiske, 1995). As Anestis et al. (2013) point out, creating a control condition for equine-related

treatments would require some creativity to cancel out the added variables introduced with EFP that are not typical of other psychotherapies and may have temporary effects on treatment outcomes. For example, EFP sessions are conducted in outdoor areas or arenas, which exposes clients to sights, smells, and interactions with nature that may have psychological benefits in and of themselves, unrelated to the interactions between the client and treatment team (Grinde & Patil, 2009; Hallburg, 2008; Wilson, 1984). Second, clients in EFP sessions will likely experience more physical exertion than those in standard talk therapies (Hallburg, 2008). Participants in a therapeutic riding program, for example, reported improved sleep and relaxation on days they worked with horses (Bizub, Joy, & Davidson, 2003), which is consistent with exercise studies in which participants reported improved mood as sleep patterns improved (Rethorst et al., 2013). A third consideration is the unknown dynamic created by the treatment team, which in EFP often consists of the client, therapist, and horse, but also other personnel who interact with clients to ensure safety of the group members (Hallburg, 2008). A related variable introduced is novelty of the treatment, which may have temporary positive effects on treatment outcomes via the instillation of hope (Anestis et al., 2013). The presence of these additional factors is important to consider when designing a research protocol that effectively cancels out their effects on the treatment outcomes (Anestis et al., 2013) and is important to do as these confounds may not be easily identified as such by providers in everyday practice (Lilienfeld et al., 2014).

These issues, among other sources of error or bias, may make a treatment appear to work when it does not (APA Presidential Taskforce on EBP, 2006; Lilienfeld et al., 2014). The APA introduced EBPP to assist clinicians utilizing new and under-funded treatments to avoid potentially restricting access to options that have not been thoroughly tested for efficacy (APA

Presidential Taskforce on Evidence-Based Practice, 2006), such as EFP. EBPP encourages clinicians to integrate information from multiple sources including research, clinical practice, and client characteristics and preferences (APA Presidential Taskforce on Evidence-Based Practice, 2006). Clinical practices include assessment, diagnosis, treatment planning, documentation and monitoring of patient progress, seeking resources as needed, and rationalizing treatment strategies, among others (APA Presidential Taskforce on Evidence-based Practice, 2006). Clinicians can make and test hypotheses about interventions within the clinical setting when research evidence is not yet established (APA Presidential Taskforce on Evidence-based Practice, 2006). Without these guidelines, clinicians are poor at recognizing deterioration in their clients (Hannan et al., 2005) and overestimate the amount of positive change their clients experience (Walfish, McAlister, O'Donnell, & Lambert, 2012). Considering the paucity of evidence for efficacy of EFP as well as the concerns raised about its rising popularity despite this, the use of EBPP in clinical practice is crucial (Anestis et al., 2013; Lilienfeld et al., 2014).

Research Question

EFP is currently being used with several disorders and populations despite little empirical support for its efficacy (Anestis et al., 2013). The first goal of this research paper is to understand who is providing EFP and what training and experience these providers have both in equine-related therapies as well as other psychotherapy modalities. The second goal is to understand how clinical decisions are made, including how providers determine EFP to be a good fit for a client, how EFP is implemented, what interventions are common to EFP, and how progress is measured.

Question 1: What are the demographics and clinical background of those providing EFP?

Question 2: How is it determined that EFP is a good fit?

Question 3: How is EFP being implemented?

Question 4: What interventions constitute EFP?

Question 5: How is progress measured?

Method

Participants

The sample was taken from providers of EFP who either advertised their services online via a personal or business website or registered on the website of an equine therapy training/certification website. Due to the expectation that providers will have an advanced degree in a mental health-related field as well as licensure to practice psychotherapy, this was listed as a requirement for participation and those without these prerequisites, including equine specialists and volunteers who may have assisted in conducting EFP sessions, were excluded from the study. While 30 participants started a survey, 17 completed. Data from one participant were removed based on responses indicating ineligibility.

Design

As the research questions were exploratory, a mixed-method design was employed, combining quantitative with qualitative responses to determine frequencies of implementation practices. Qualitative open-ended questions were used to obtain a wider range of responses than might be captured in a purely quantitative design, in a way that limited demand characteristics.

Procedure

Permission for the study was granted by the University of Denver's Institutional Review Board. Two organizations, PATH and EAGALA, provided access to a list of providers and/or facilities registered on their websites. Both were contacted via email and gave permission to contact providers listed on their websites. Two other organizations were contacted but either

declined or did not respond. PATH and Human-Equine Relational Development Institute agreed to post an advertisement flyer (Appendix C) for the study on their social media accounts. An internet search for “equine psychotherapy” was also completed to obtain contact information for practitioners providing EFP that were not listed on the above websites. When a direct contact for the psychotherapist was unavailable through the website, the general email account for the facility was used. A list of 205 providers or facilities was generated from these methods. An email invitation was sent out via the principal investigator’s Outlook account that included a link to the survey (Appendix A). Of the 205 messages sent, 16 were returned as undelivered. Clicking on the link in the email automatically directed participants to the online survey, which began with the informed consent (Appendix D). The survey software indicated 30 participants clicked on the link, and 17 completed the survey. Participation was voluntary, and participants were offered a \$10 gift certificate as an incentive for their participation.

The questionnaire was created to best answer the research questions (see appendix A), combining quantitative and qualitative responses. Section One included demographic information to understand the sample, including age, gender, ethnicity, education background, licensure and certification, background training and interest in EFP, and the theoretical orientation through which they understand their clients. Section Two focused on how providers determine EFP to be a good fit for the client, including diagnosis and treatment planning. Section Three focused on logistical factors of implementation, including the type of facility, how often clients are seen, how sessions are structured, and how often EFP is utilized as a stand-alone treatment versus adjunct treatment. Section Four queried participants about interventions common to EFP sessions, adapted from O’Callaghan’s (2008) list of 18 techniques of AAI.

Section Five addressed activities that determine how progress is measured and how and when to terminate treatment.

Analysis

Means, ranges, and frequencies were calculated for the quantitative survey data. Data from the open-ended survey questions were analyzed for themes, grouped by relevance, and tallied to determine the percentage of participants with that thematic response.

Results

Section One: Demographics and Background

Results indicated a mean age of 51.3 (SD = 11.8) years. All participants were White/Caucasian, with 94% female and 6% non-binary gender. All participants indicated licensure, with master's degrees in social work (37.5%), counseling psychology or community counseling (43.75%), marriage and family therapy (12.5%), or education psychology (6.25%). Participants use a variety of theoretical orientations to understand their clients, including Jungian (6.3%), Behavioral (18.8%), Cognitive Behavioral (25.0%), Rational-Emotive (6.3%), Acceptance and Commitment (6.3%), Client-centered (including Humanistic, person-centered, client-focused, and family-centered, 25.0%), existential (6.3%), experiential (6.3%), neurodevelopmental/attachment (6.3%), psychodrama (6.3%), interpersonal neurobiology (6.3%), and trauma-informed (6.3%). Eclectic (12.5%) was also used, along with 25.0% who mentioned multiple orientations. Although two participants clearly indicated EFP to be the only form of psychological treatment they offer to clients, three more were unclear, listing individual, family, couples, and/or group counseling without indicating a specific format. Play therapy, Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy, Motivational Interviewing, Cognitive Processing Therapy, Eye-Movement Desensitization and Reprocessing, Trauma-

focused CBT, psychodrama, Parent-child Interaction Therapy, Internal Family Systems Model, Somatic Psychology, transactional analysis, and traditional talk therapy were all mentioned by the remaining participants.

Participants became interested in EFP through owning horses (37.5%), professional experiences with EFP (25%), personal experience with horses as healing (18.8%), family member (6.3%), or through beliefs in the horses as healing (12.5%). Certifications in EFP including EAGALA (50%), PATH (18.8%), and Natural Lifemanship (12.5%) with 37.5% not specifying. Some participants indicated multiple certifications (18.8%), with non-EFP certifications also listed including drug and alcohol treatments, drama therapy, trauma-focused treatments, and education-related services (25%). Aside from EFP certifications, participants described additional training experience with EAGALA (62.5%), OK Corral (12.5%), PATH (31.3%), personal riding experience and horsemanship training (18.8%; Parelli, Renaud, Hunt and Dorrance were each mentioned), training and certification in other animal assisted therapies (18.8%), trainings in multiple EFP modalities (12.5%), trainings specific to EFP with special populations, such as veterans and military (12.5%), and reading (6.3%). Participants averaged 5.5 (SD = 2.6) years providing EFP; 25% also provide EAL, 12.5% provide therapeutic riding, and the remainder (62.5%) do not provide either equine activities. Most participants listed EAGALA as a resource for planning their EFP sessions (75.0%) followed by PATH (25%). Other resources mentioned were books and articles from various authors including Kay Trotter, Teri Renaud, Linda Kohanov, Joy Nussen, Temple Grandin, and Susan Jung, some specific to equine work and others related to addiction work, animal behavior, military, trauma, and therapy work. Participants provide EFP Rarely (with few clients, 18.75%); Sometimes (about half my clients, 31.25%); Often (with most of my clients, 37.5%); and Always (12.5%).

Section Two: Implementation Practices

Results indicated participants provide EFP at Therapeutic riding center (43.48%), public stable/arena owned by someone else (4.35%), private stable/arena owned by someone else (21.74%), stable/arena owned by myself (13.04%), residential facility (horses and stable on site, 8.7%), and Other (8.7%). Participants were asked if they follow an established protocol, to which five (31.25%) answered no, and 11 (68.75%) answered yes, adding EAGALA (43.7%), Equines and You (6.3%), PATH (6.3%), Safety First (6.3%), Natural Lifemanship (6.3%), and facility developed protocol (12.5%). Of the participants following a protocol, eight indicated closely or strictly adhering (50%), two described basing judgments on client needs (12.5%), and one participant indicated loosely adhering and allowing sessions to develop organically (6.3%). Based on our sample, participants use EFP with individuals (81.3%), groups (93.8%), and couples/families (62.5%). Treatment duration for our sample is dependent upon the client and/or the issue (56.3%), based on length of residential stay (6.3%), or a set number of sessions (18.75%). Most indicated the number of sessions is determined by client needs, treatment plan or goals, with most indicating this to be the rule for individuals, families, and some groups (81.3%). Eight participants described set protocols for groups (50.0%). Other factors for duration of treatment were length of stay in a residential facility (12.5%) and payment types (12.5%). One participant stated the number of sessions is determined by the director of the program (6.3%). Typical sessions are 45 to 60 minutes (62.5%), 90 minutes (25%), or 105 to 120 minutes (25%), with groups in the upper range. Clients are seen once per week (62.5%) or every other week (37.5%).

The participants claimed to use EFP is as a stand-alone treatment, primary treatment supplemented with outside psychotherapy, secondary treatment as a supplement to

psychotherapy by the participant or by an outside provider, at similar frequencies, between sometimes and half the time (See Table 1). Participants practice EFP alone (12.5%) or with the assistance of an equine specialist, horse handler, or certified instructor (81.3%), another trained support, such as mentors, interns, coaches, volunteers, or staff peers (56.3%), or a family member (12.5%). The way participants structure EFP sessions varied; a pattern emerged indicating some type of check-in (68.8%), grooming of the horse (31.3%), activity relevant to treatment goals (87.5%), followed by processing of the activity (43.7%), to be common. Variations included completing a SUDS scale pre-and post-session, ending the session with a quiet moment with the horse, journaling, completing the Human Animal Interaction Scale, and assigning homework. Two participants indicated the sessions can be different for each client (12.5%). Most participants indicated utilizing a treatment plan with their clients (87.5%), either through a formal intake session (37.5%) or informal discussions with clients (31.3%). Others were not clear (12.5%) or do not use treatment plans (12.5%). Termination of treatment is based on progress or no progress on goals (62.5%), having a set number of sessions (18.8%), discharge from residential treatment (12.5%), or payment/financial reasons (6.3%).

Section Three: How Do You Determine EFP to be a Good Fit?

Participants listed several referral sources, including physicians (25.0%), other mental health providers (81.3%), community agencies (43.7%), schools (31.3%), courts (6.3%), veteran programs (12.5%), and self-referral through word of mouth (25.0%) or websites (31.3%). One provider works with a VA residential program for which participation in the EFP program is mandatory. Most participants use a diagnosis to inform treatment (87.5%). Clients are diagnosed by the referring provider (43.7%), by the participant (43.7%), or by both/either (25%).

Participants reported experience treating many disorder, symptoms, and behaviors with EFP. These include PTSD and trauma (93.8%), anxiety disorders (93.8%), and depression (87.5%). Also common were adjustment disorders (43.7%), bipolar disorder (37.5%), substance use disorders (31.3%), autism/Asperger's (25.0%), attention deficit hyperactivity disorder (43.7%), and conduct/oppositional defiant disorders (37.5%). Also mentioned were personality disorders (18.8%) and attachment disorders (18.8%). Grief and loss, anger, problems with primary support group and socialization, medical induced mental health issues, and communication issues, were each mentioned once. Of the disorders, symptoms, or behaviors listed, 75% of participants reported EFP to be well-suited, 18.8% believe all/any to be well-suited, and 18.8% emphasized trauma-related issues to be particularly well-suited for EFP. Some rule-outs or cautions mentioned by participants include history of aggressive or antisocial behavior towards humans or animals, (31.3%), severe symptoms of cognitive impairment, psychosis, impulsivity, anxiety, or attention (31.3%), Borderline Personality Disorder (12.5%), fear of horses (12.5%), allergies (6.3%), and none (18.8%).

Section Four: Interventions

Interventions that are standard practice for EFP. Results are reported in Table 2. Commenting on spontaneous interactions and allowing the horse to be present without any directive interventions were chosen by all participants. Allowing the horse to engage with the client in spontaneous moments that facilitate therapeutic discussion, Reflecting or commenting on client's relationship with the horse, Encouraging client to interact with the horse by touching or grooming the horse, and Observing and discussing horse behavior in the herd, were each selected by at least 14 participants.

Section Five: Measuring Progress

Participants indicated a mixture of assessment practices for measuring progress. Results indicated that 68.75% of participants use quantitative measures and 31.25% do not. Measures used include depression, anxiety, and PTSD measures, including the Personal Health Questionnaire-9 (18.8%), the General Anxiety Disorder-7 (6.3%), and the PTSD Checklist (PCL, 18.8%). Two participants described a measure adapted from a five-factor personality model by Goldberg (12.5%). One participant reported use of the Subjective Unit of Distress Scale (6.3%). Another indicated two scales, the Human Animal Interaction Scale and the Metaphor Record, which were developed at her facility. One participant described a facility-developed, standardized method for monitoring progress on treatment plan goals. Other participants were less specific, indicating progression on skills, standard measures, or all. Many of the participants reported giving assessments at pre- and post-treatment (62.5%), with some giving assessments at every session (31.3%), and at treatment plan updates (6.3%).

More participants indicated using qualitative assessments than quantitative (81.3%). Clinical and behavioral observations (62.5%), client report/testimonials (43.7%), family report (12.5%), outside provider report (12.5%) and treatment plan review (6.3%) were mentioned.

Discussion

EFP is a relatively misunderstood treatment modality that is gaining in popularity despite a lack of evidence based on efficacy studies (Anestis et al., 2013; Fine, 2015; Selby & Smith-Osborne, 2013). The APA provides guidelines for clinical practice so that clinicians may evaluate new and under researched treatments (APA Presidential Taskforce on EBP, 2006). With a lack of studies demonstrating efficacy, providers of EFP must rely more heavily on clinical observations and anecdotal evidence from clients and other providers, which may make their judgments about the effectiveness of their treatments vulnerable to bias (Anestis et al., 2013;

Herzog, 2011; Lilienfeld et al., 2013). This study set out to understand more about EFP providers including who they are and how they implement EFP, to determine how closely they adhere to EBPP standards. A mixed-method design was used via an online survey to gather responses. Participant responses were analyzed for themes and reported by frequency. They are discussed below by research question.

Question 1: What are the demographics and clinical background of those providing EFP?

According to results, providers of EFP tend to be middle-aged white females with previous experience with horses. According to the US Department of Agriculture, horse owners tend to be female, 38-45 years of age, living in rural areas with the median income \$60,000 per year (Equo, 2017), which seems consistent with our sample. Considering how often previous experience with horsemanship is mentioned for several of the certifying organizations (see Appendix E), this may disqualify certain subsets of the population who may not have easy access to equines. It may also make these providers susceptible to bias as they are already primed to believe horses have a beneficial effect (Herzog, 2015).

Professionally speaking, this sample tended to hold counseling or social work master's degrees and be trained in the EAGALA model. According to Division 17 of the APA (Roger & Stone, n. d.), counseling psychologists historically have been trained in a holistic approach, focused on strength-based models of treatment, rather than the more pathological approach of clinical psychologists. Clinical social work is described in the same way (Humanservicesedu.org, n. d.) which may explain why EFP, as a developing treatment, may be attractive to them as an adjunct to other treatments. Most of the participants were trained and practice in other treatment modalities, including several evidence-supported therapies, and have varying theoretical

approaches to understanding their clients. A minority of our sample uses EFP exclusively, indicating a majority combine their EFP practice with other treatment modalities.

Question 2: How is it determined that EFP is a good fit?

Participants reported success with several diagnoses, behaviors, and symptoms, as well as some rule-outs for incompatible behaviors. Trauma, anxiety disorders, and mood disorders garnered the most responses as well-suited for EFP, which is consistent with the literature (Earles et al., 2015; Kemp et al., 2014;). Severity of symptoms that may interfere with safety, including volatility, impulsivity, active psychosis, and cognitive impairment were identified as rule-outs for this therapy. Referral sources varied considerably, supporting previous mentions of a thriving field (Selby & Smith-Osborne, 2013), and included medical, social services, community/court, mental health, and self-referral. Generally speaking, participants see EFP as a beneficial treatment for a variety of diagnoses, behaviors, and symptoms, and as one participant noted, the effectiveness of the treatment may be more dependent on the expertise of the treatment team with a specific disorder than on EFP. It seems providers are making determinations based on diagnosis and considering severity of symptoms in their determination of appropriateness for clients.

Question 3: How is EFP being implemented?

According to our sample, many providers see clients at therapeutic riding centers. A therapeutic riding center is typically a non-profit-based organization that offers a variety of equine therapies with a herd of horses specifically selected for that purpose, but can be a single provider (PATH, n. d.). Horses may be owned, leased, or borrowed. Accreditation for riding centers is voluntary but ensures a minimum standard of safety for horses and riders. Other settings included stables primarily privately owned, either by the participant or someone else, or

residential facilities. One participant indicated bringing the horse(s) to the treatment setting, but primarily clients come to the horse's setting rather than the reverse. This sample indicated a variety of settings that would be beneficial to study more in-depth to understand how each may affect client experiences but is beyond the scope of the current paper.

A major question about how EFP is implemented is how providers combine it with outside psychotherapy, if at all, and how the treatment is structured both by session and by course. Anestis et al. (2013) questioned whether providers see EFP as an adjunct therapy, as it is often described in reviews of AATs, yet observed that it seemed to be used as a primary treatment in research studies. Our sample indicated that it is primarily used in conjunction with other psychotherapies but is considered a stand-alone or primary treatment by many participants, even if not used primarily as such. A majority of our sample work in conjunction with other professionals during sessions, such as horse specialists or volunteers, and most described structuring sessions with both specific (check-in, grooming, processing interactions) and open-ended (activity with horse) events during typical meetings. Most participants reported basing their practice closely on a manual or model, which alludes to a standardized approach to EFP implementation within our sample, but at the same time bases decisions about course of treatment on client variables, especially when providing EFP individually or to couples/families. Responses indicate groups typically have a set number of sessions.

Most providers, whether providing primary or adjunct treatment, have a process for treatment planning and termination. Although some have a formal intake process and others describe informal discussions with clients, it seems the primary method of determining course of treatment is via individualized treatment planning and progress or lack of progress on client-identified goals. Due to many providers contacted through an EAGALA website, our sample

leans heavily toward that model, which may dictate a stricter approach to EFP than other models and may not represent practices of non-EAGALA providers. A broader sample may help determine differences in implementation across the different certification programs.

Question 4: What interventions constitute EFP?

Consistent with experiential therapy practices and theory, EFP providers most readily identified interventions that allowed for the client to naturally bring out interactions with the horse (see Table 2). Commenting on spontaneous interactions, allowing the horse to be present without any directive interventions, allowing for spontaneous interactions, and encouraging interaction with the horse are consistent with that belief. Other top interventions were relational, including commenting on the client-horse relationship, and observing and discussing horse behavior in the herd, or horse-horse relationships in other words. Most interventions were selected by at least half of participants, which may reflect a difference among those who are more structured versus those who are more organic in their approaches, as the interventions selected by fewer participants seem more directive, such as, “Providing psychoeducation on client's symptoms and how they may present in interactions with the horse.” Rather than providing psychoeducation to a client, some EFP providers may choose to allow the symptoms to occur naturally and allow the client to connect the symptom in the moment, as it presents with the horse, to the symptom as it presents in everyday life. One participant noted that facilitators do not interpret what is going on for the client. Perhaps a better way to assess interventions in practice in the future would be to observe facilitators in action to see what interventions they use at what frequency and compare them across certification backgrounds.

Question 5: How is progress measured?

As mentioned in the literature review, regular assessment of symptoms is considered best practice to determine progress and make appropriate clinical decisions. Most participants indicated using quantitative and/or qualitative assessments at least pre- and post-treatment. Some described assessments every session. The most common indicator used for measuring progress appears to be client report and/or clinical observation of progress toward treatment goals. About half of participants listed multiple standardized measures, including those for PTSD, anxiety, and depression. Those who reported a trauma focus or describe themselves as trauma-informed appear to be more likely to use regular assessment with standardized measures. As treatment of trauma is currently the most well-researched and informed by its own best practice guidelines, this result indicates an adherence to EBPP guidelines for those with that specialty in this sample.

One participant indicated seeking outside observations from family and other providers for qualitative data on client progress. Evidence supports the regular use of outside reports as an additional measure of progress, along with standardized measures of client progress and clinical observations, that are independent of therapist- and client-related bias (Riemer, Kelly, Casey, and Haynes, 2012). Such feedback systems are not commonly used in clinical practice (Mellor-Clark, Cross, Macdonald, & Skjulsvik, 2016) and implementing new feedback protocols can be difficult (Persons, Koerner, Eidelman, Thomas, & Liu, 2016). Obtaining this information can elucidate iatrogenic effects much earlier; considering 10% of therapy consumers are expected to deteriorate in treatment, identifying poor responses and modifying or stopping harmful interventions as soon as possible is desirable (Hatfield & Ogles, 2006).

Adherence to EBPP recommendations

Considering the paucity of evidence to inform providers of the efficacy and/or effectiveness of EFP, fewer sources of information are available for providers upon which to

base their clinical decisions with their own clients. Although not all providers surveyed reported consistent EBPP practices, a majority indicated adherence to some recommended practices such as having a broad base of experience from which to draw information, combining standardized protocols with interventions specifically chosen for individual client needs, assessing client progress with a combination of quantitative and qualitative measures, and utilizing diagnostic information to inform treatment planning. Adherence to all the above was not 100% but increasing adherence to EBPP and treatment protocols is a common theme in the EBPP literature (Park, Chorpita, Regan, & Weisz, 2015; Persons et al., 2015). One recommendation based on these results would be to add more feedback from outside sources to confirm improvement in functioning at home, work, or school, and to utilize client feedback regularly to enhance progress toward goals or identify and respond to lack of progress early.

Limitations

Although this was an exploratory study, a few limitations should be considered in light of the above discussion. First, the sample size was smaller than desired, and may not reflect practices across different training and certification backgrounds. Due to time restraints, word of mouth advertisement was not feasible. According to feedback from a few recipients of the email sent to providers listed on the PATH site, the designation of equine psychotherapy provider may have resulted in equine specialists who assist in EFP sessions believing they were eligible for the study, as they technically provide equine psychotherapy as part of a team. Indeed, one individual was identified as an equine specialist and not psychotherapist through the responses on the survey. Another limitation was the format of the survey. An online format was chosen for time, as it was assumed more online surveys could be completed in the short time-frame than individual interviews. Several surveys were started but not completed, possibly due to the length.

Most of the unfinished surveys were abandoned during the first section, demographics, with some abandoned at later stages, but no clear pattern emerged with those abandoned at later stages.

Another limitation of this study is that it is self-report. The same biases discussed earlier that may interfere with clinical observations may be in play here; providers may be eager to make a good impression regarding their clinical practices. They may overreport the benefits and underreport iatrogenic responses in an effort to support the treatment. The nature of the study may have encouraged self-selection based on those who already prescribe to scientific principles and research and discouraged those who may disagree with the importance of research in clinical practice.

Areas of future study

Research in the implementation of EFP in both controlled studies and clinical practice is needed. Relatively little is known about efficacy or effectiveness. Typically, research stems from RCTs, which are non-existent currently, and develops from efficacy to effectiveness research. However, EFP appears to be one treatment that is growing from word-of-mouth rather than research. RCTs are needed, as are analyses of cost to benefit ratios, observational studies of interventions across EFP training backgrounds, and effectiveness of EFP on individual disorders and personality traits. Due to the nature of the treatment, looking at the accessibility of this treatment both to new providers as well as clients would be prudent.

In response to the complexity of this treatment and the challenges it creates in controlled studies, the following recommendations are made for RCT design: Based on recommendations for rule-outs from this sample, the RCT sample should consist of individuals without animal/dust allergies, free from severe symptoms that may affect safety and be comfortable around large

animals. Random assignment should be conducted between an EFP treatment group and a control group that either provides a comparable treatment, such as an EFL group focused on horsemanship, or some type of interactive experience that mirrors the time the treatment group is active in the arena, meets at the same time of day, duration, and level of activity to control for outdoor exposure, time with the equine, and exercise. Equine handlers in both groups need to be blind to whether their group is the control or treatment group, just as participants.

Assessments should combine quantitative and qualitative data and take into consideration the experience of the participant as much as the change in quantitative data. One presumed draw for this therapy is its attractiveness to those who do not do well in traditional talk therapy, a vague description that would need to be clarified and clearly defined to be tested. If this claim about EFP are true, then comparable or better changes on quantitative outcome measures, lower attrition rates, and higher qualitative satisfaction scores should be evident for this population, when compared to traditional psychotherapy techniques. Finally, long-term follow-up scores are recommended to determine successful outcomes due to treatment rather than novelty or other spurious variables.

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Appendix A

Provider Survey

I. Demographics and background:

- a. Age: _____
- b. Race/Ethnicity (check all that apply)
 - i. Asian or Pacific Islander
 - ii. Black/African American (non-Hispanic)
 - iii. Latinx/Hispanic
 - iv. Native American/American Indian
 - v. White/Caucasian
 - vi. Other: _____
- c. Gender
 - i. Female
 - ii. Male
 - iii. Non-binary
- d. Background:
 - i. What academic degree(s) do you hold, if any, and in what field(s)?
 - ii. What licenses and/or certifications do you hold? Please specify the issuer.
 - iii. Through what theoretical orientation do you understand your clients and their problems?
 - iv. How long have you been practicing EFP? _____
 - v. What training do you have specific to EFP?
 - vi. What interested you in EFP?

- vii. What resource(s) or manual(s), if any, do you use as a guide for developing your EFP practice?
- viii. What other modalities of equine-related interventions, if any, do you provide or have provided in the past?
- ix. What other modalities of psychotherapy, if any, do you provide or have provided in the past?
- x. How often do you use EFP?

Never Rarely (few clients) Sometimes (about half my clients) Often (most clients)

Always (with every client)

II. Questions about how EFP is used: Please answer the following questions based on what is typical for you when using EFP, and please feel free to add your own response or expand on a response if necessary. Questions about protocols and procedures are not meant to imply these should be done with clients.

a. In what type of setting(s) do you provide EFP? Check all that apply.

- i. Therapeutic riding center
- ii. Stable/arena owned by someone else, public
- iii. Stable/arena owned by someone else, private
- iv. Stable/arena owned by myself
- v. Residential facility (horses and stable on site)
- vi. Other _____

b. Do you follow an established protocol?

- i. If so, which one?
- ii. If so, how closely do you adhere to the protocol?

- c. How do you provide EFP? Check all that apply.
 - i. Individually
 - ii. In groups
 - iii. Families/couples

d. How many sessions are typical? _____ Also, please indicate one of the following:

- i. Depends on the client and the issue; nothing is set.
- ii. There is a specific number of sessions per treatment round.

e. How long is the typical session? _____Minutes/Hours

f. How often per week is a client seen for EFP?

g. How often do you use EFP:

i. as a stand-alone, primary treatment (no other psychotherapeutic interventions are provided by you or others for the relevant treatment goals, of which you are aware and/or collaborate)

Never Rarely Sometimes Often Always

ii. as a stand-alone, primary treatment supplemented by psychotherapy outside the EFP sessions, as needed

Never Rarely Sometimes Often Always

iii. as a supplemental treatment, secondary to psychotherapy I provide

Never Rarely Sometimes Often Always

iv. as a supplemental treatment, secondary to psychotherapy with an outside provider, with whom I, as the EFP provider, collaborate to meet specific treatment goals

Never Rarely Sometimes Often Always

- h. Who aside from you (the psychotherapist), the client, and the horse, is present in EFP sessions?
 - i. What are their roles?
 - i. How is a typical EFP session structured?
 - j. Do you utilize a treatment plan with your clients?
 - i. If so, please describe how you go about treatment planning with a particular client.
 - k. How do you determine when to terminate treatment?
- III. How determination is made for EFP
- a. How are your clients referred for treatment?
 - b. Do you use a diagnosis to inform treatment?
 - i. If so, how are your clients diagnosed?
 - 1. By referring provider
 - 2. By you
 - c. What disorders, symptoms, or behaviors have you treated with EFP?
 - d. What disorders, symptoms, or behaviors seem well-suited for EFP?
 - e. What are some rule-outs or issues that do not respond well to EFP?
- IV. What therapeutic interventions would you consider standard practice for EFP work?
(select all that apply)
- a. Reflecting or commenting on client's relationship with the horse.
 - b. Encouraging client to interact with the horse by touching or grooming the horse.

- c. Encouraging client to tell therapy animal about client's distress or concerns.
- d. Interacting with the horse by having the horse follow commands.
- e. Encouraging the client to perform commands with the horse.
- f. Commenting or reflecting on spontaneous client-animal interactions.
- g. Sharing the horse's family history (e.g., lineage, breed, etc.) with the client.
- h. Sharing history of the horse with the client.
- i. Sharing stories and metaphors with equine themes with the client.
- j. Encouraging the client to make up stories involving the horse.
- k. Using the client-horse relationship, such as, "If [horse] were your best friend, what would he know about you that no one else would know?" And/or "Tell [horse] how you feel and I will just listen."
- l. Encouraging client to recreate/reenact experience where the horse plays a specific role.
- m. Allowing the horse to be present without any directive interventions.
- n. Creating specific structured activities for a client with the horse.
- o. Allowing the horse to engage with the client in spontaneous moments that facilitate therapeutic discussion.
- p. Allowing time to process interactions away from the horse.
- q. Modeling appropriate and safe interactions with the horse.
- r. Providing psychoeducation on client's symptoms and how they may present in interactions with the horse.
- s. Providing rationale for therapeutic work with equines.
- t. Observing and discusses horse behavior in the herd.

u. Other: _____

v. Other: _____

V. Measuring progress

a. Are standardized quantitative measures used to track progress in treatment?

i. If so, which ones?

ii. When and how often are measures administered (check all that apply)?

1. Pre- and Post-treatment

2. After a set number of sessions (specify: ____)

3. At every session

b. Are qualitative methods used to determine progress in treatment?

i. If so, what are they?

c. What methods, if any, have you found to be most effective at gauging progress in treatment?

VI. What information, if any, do you feel important to add in order for me to understand how EFP is implemented?

VII. Are you interested in being contacted for future research on equine-related therapies?

This information will be stored separately

a. Yes- please provide contact info

b. No

VIII. Please provide mailing address for \$10 gift card. I appreciate your time and input!

a. Name

b. Address line 1

c. Address line 2 (optional)

- d. City
- e. State
- f. Zip Code

Appendix B

Recruitment Email

Dear [Participant Name],

My name is Mandi Turner and I am a student from the Professional School of Professional Psychology at the University of Denver. I am writing to invite you to participate in my research study about Equine Facilitated Psychotherapy. You are eligible to be in this study because you are listed as a provider of EFP on either the EAGALA website, Path, Int. website, or through a general internet search.

If you decide to participate in this study, you will complete an online survey regarding how you provide EFP, your training and educational background, and demographic information. The survey generally takes 30 minutes to complete and doing so will provide information to assist researchers develop better protocols to determine the efficacy and usefulness of EFP. No compensation will be given for your participation.

This survey is completely voluntary. You can choose to be in the study or not. If you would like to participate, please click on the link below. You may contact me at mandi.turner@du.edu with any questions or concerns.

Thank you very much.

Sincerely,

Mandi Turner

Graduate School of Professional Psychology

University of Denver

Appendix C

Recruitment Flyer



University of Denver

Graduate School of Professional Psychology

Is conducting a research study on:

How Equine Facilitated Psychotherapy (EFP) providers implement this treatment in clinical practice

If you:

- provide or have provided psychotherapy supplemented with horse-related activities and/or interventions
 - Are 18 years or older
 - Are licensed or supervised by a licensed mental health clinician
 - Reside and practice within the United States of America

You may be eligible for this study.

This is an internet-based survey which takes approximately 30 minutes to complete.

By giving your time for this study you may help advance efforts of researchers in conducting more effective studies that contribute to evidence of efficacy and further understanding of how it works

Participants will receive a \$10 gift certificate for their participation.

If interested, or for more information, please contact principal investigator Mandi Turner at mandi.turner@DU.edu or faculty advisor Dr. Laura Meyer at Laura.Meyer@DU.edu

Appendix D

Consent Form



**University of Denver
Graduate School of Professional Psychology
Consent Form for Participation in Research**

Title of Research Study: Horses and Psychotherapy: How Equine Facilitated Psychotherapy is being implemented

Researcher(s): Mandi Turner, MS, Graduate School of Professional Psychology, University of Denver; Laura Meyer, PhD, Graduate School of Professional Psychology, University of Denver

Study Site: The survey is online and can be accessed by clicking the next arrow, below.

Purpose

You are being asked to participate in a research study. The purpose of this research is to further understanding of how practitioners utilize equines in psychotherapy in order to develop better research protocols.

To be eligible for participation you must have provided psychotherapy aided by the presence of a horse, which has been referred to as Equine Facilitated Psychotherapy, Equine Assisted Psychotherapy, Equine assisted therapy, and others. A provider will typically have a background education in providing psychotherapeutic treatment and be licensed or supervised by a licensed clinician in mental health, social work, or related field. Equine Facilitated or Assisted Learning, Hippotherapy, Therapeutic Riding, and other equine-assisted activities without a psychotherapy component are not of interest in the current study.

Procedures

If you participate in this research study, you will be invited to complete an online survey regarding your clinical use of Equine Facilitated Psychotherapy, which typically can be completed within 15 to 30 minutes.

Voluntary Participation

Participating in this research study is completely voluntary. Even if you decide to participate now, you may change your mind and stop at any time. You may choose to discontinue the survey for any reason without penalty or other benefits to which you are entitled.

Risks or Discomforts

Due to the nature and design of this study, no risk of harm or discomfort is expected.

Benefits

Possible benefits of participation include improving the practice of EFP and contributing to knowledge in the field of equine-related treatments.

Incentives to participate

You will receive a \$10 gift card for your time.

Confidentiality

The researcher will separate contact information from survey information to keep any identifying information safe throughout this study. All survey responses will be anonymous. Your individual identity will be kept private when information is presented or published about this study and will be collected for the sole purpose of delivering the gift certificate, after which time (May 1, 2018) this information will be destroyed.

Questions

If you have any questions about this project or your participation, please feel free to ask questions now or contact Mandi Turner at Mandi.Turner@DU.edu, or Dr. Laura Meyer at Laura.Meyer@du.edu at any time.

If you have any questions or concerns about your research participation or rights as a participant, you may contact the DU Human Research Protections Program by emailing IRBAdmin@du.edu or calling (303) 871-2121 to speak to someone other than the researchers.

Before you begin, please note that the data you provide may be collected and used by Qualtrics as per its privacy agreement. This research is only for U.S. residents over the age of 18. Please be mindful to respond in private and through a secured Internet connection for your privacy. Your confidentiality will be maintained to the degree permitted by the technology used. Specifically, no guarantees can be made regarding the interception of data sent via the Internet by any third parties.

Please take all the time you need to read through this document and decide whether you would like to participate in this research study.

If you decide to participate, your completion of the research procedures indicates your consent. Please keep this form for your records.

Appendix E

Credentialing and Training in EFP

One major criticism of EFP is the many different organizations training and certifying providers. Certification is not mandatory for individuals to practice EFP, and aside from the methods of training and credentialing listed below, there are numerous books that provide guidance on EFP interventions and activities that can be purchased on Amazon with no prior training or experience with horses. Credentialing is one way consumers can be sure their provider has sufficient training to offer safe experiences. However different certification programs have vastly different requirements and standards, reviewed below.

Certification Board for Equine Interaction Professionals (CBEIP, n.d.) is an organization which offers a voluntary certification examination for professionals who use horses as part of their therapy, education, or coaching practice. They do not offer training nor do they endorse any training or certification programs, and thus use the term Equine Interaction Services to describe the practice. The exam is 150-item multiple choice and is administered via Professional Testing Corporation. Three versions are available, depending on the background and focus of the professional, either mental health, education, or equine interaction facilitation. The exam is comprised of approximately 25% focus on assessment, evaluation, and planning knowledge, 60% on facilitation skills, and 15% on administration and risk management skills. For the mental health exam, a master's degree and current proof of licensure is required, followed by 1,000 hours of documented experience working with horses, in order to take the exam. Recertification may be achieved through completing 40 hours of continuing education over a three-year period in facilitation, horse behavior or horsemanship, or by attending or presenting at conferences.

Recertification may also be completed through re-examination on the third year after certification. CBEIP also requires agreement and compliance with their code of ethics.

Equine Assisted Growth and Learning Association (EAGALA, n. d.) is based on the EAGALA Model, which among other differences, does not allow any mounted work to be done with clients and is always conducted as a team with an equine specialist available for safety. There are two levels of certification offered; the standard and an advanced certification. Licensure is required to take the program and anyone interested must complete a pre-training webinar that provides an overview of the model. Next is a five-day hands-on training that provides understanding of how to apply the model, including facilitation skillsets, understanding roles, treatment planning and progression, learning and practicing intervention strategies, utilizing transference to facilitate client process, and understanding ethical standards as they apply to this model. An online assessment must be completed after the training, and a professional development portfolio submitted, which includes a commitment to adhering to the model, before certification is approved. The advanced certification program continues by attending the fundamentals training a second time, completing 300 hours of practice with the EAGALA model, completing a mentorship program, attending a skillset intensive, at least two additional trainings or conferences, submitting an article for publication in the EAGALA Newsletter, and an application for advanced certification. EAGALA requires continuing education for certification renewals, every two years.

Professional Association of Therapeutic Horsemanship International (PATH, n. d.) provides certification for Equine Specialists, the professional responsible for the safety of the horse and participants, and teaching horsemanship skills to participants. Although licensed mental health providers may take this certification in order to act in a dual role as therapist and

equine specialist, it is primarily aimed at those without an advanced degree. Participants must be 21 or older to attend, be a member of PATH, attend an on-site workshop, and pass a horsemanship assessment. Within a year of completing these steps, submission of a portfolio, including documentation of 20 hours of education in equine behavior and management, 60 hours of hands-on experience in EFP, references from mental health and equine professionals, a signed code of ethics form, and two exams covering standards and EFP from the equine specialist perspective, is required for the certification. Renewal is done annually and requires 20 hours of continuing education.

Natural Lifemanship (NL, n. d.) was developed by Tim Jobe, a former horse trainer who adapted his training methods to focus on relational bonds based on work with at-risk youth. Also an early founder of EAGALA, Jobe has continuously updated his methods, based on relational principles rather than techniques, to refine the focus of the program to trauma-based treatment. Rather than seeing the horse as a tool for learning, and the relationship between horse and participant as a metaphor for other relationships, NL views the horse-human relationship as a real relationship in which the participant must make genuine change to achieve a desired connection. The changes made in the ring will therefore transfer to other relationships outside the ring. NL incorporates both ground work and mounted riding, referred to as Relationship Logic and Rhythmic Riding, where ground work is considered foundational to riding. While the relationship-building phase focuses on building healthy attachment with the goal of attunement between participant and horse the riding stage is focused on continuing the progression of the relationship, assist the participant in self-regulation skills, and facilitate the processing of trauma through greater control of arousal. Certification requires licensure as a mental health

professional, attending trainings, complete 18 consultations, recorded assignments, 60 clinical hours using the NL methods, and maintaining membership status throughout certification.

Institute for Human-Animal Interaction (IHAI, n. d.) offers an Equine-Assisted Mental Health (EAMH) Practitioner Certificate for post-master's professionals and graduate students through the University of Denver. Completed in one academic year, it includes three distance learning courses, three residential workshops, 50 hours of supervised client work and 50 hours of additional trainings. Prior experience with equines is prerequisite for admission. Certification is through the CBEIP.

Human-Equine Alliance for Learning (HEAL, n. d.), is a set of interrelated principles referred to as the Six Keys to Relationship. The Keys include body-centered awareness, boundaries, social incongruence and self-judgment, leadership, creativity, and authenticity and acceptance. The HEAL program for mental health professionals is 5-months long, including a one-week on-site instruction followed by 10 to 12 hours per week of distance learning, assignments, and peer conferences. The last week is again on-site supervision with HEAL clients. A master's level education in a mental health field as well as previous experience with a horse are highly recommended.

The Human-Equine Relational Development Institute (HERD, n. d.) offers a certification in EFP completed over five modules over the span of a year. A bachelor's degree from a regionally accredited college or university is required for admission. Topics include sharing space and entering into the herd, the effects of being with a horse, deepening relationships between the horse and client, facilitating change, and integration of theory and practice.

Gestalt Equine Institute of the Rockies (GEIR, n. d.) offers a two-year training program providing instruction in Gestalt Equine Psychotherapy. Training includes eight four-day on-site

trainings, written assignments, assessment of horse knowledge and riding ability, supervision, assessment on Gestalt theory, and a final project. Although the program is open to anyone, only licensed professionals receive certification in the therapy.

Equine Psychotherapy Institute (EPI, n. d.) is an Australian organization that requires licensure as a mental health practitioner for its certification and training program. The website describes how it attempts to bring the program in line with the American standard set forth by the CBEIP, to include training in many of the models listed above. The Foundation Training Program includes 126 hours of training, supervision and assessment. Advanced Training is an additional 222 hours including specialist training, supervision, and assessment. A one-year membership is included, after which renewal is contingent upon completion of 20 hours of continuing education and experience in the field. Practitioners are expected to be competent in understanding and facilitating the change process through an experiential approach, understanding horses including comfort and safety, and understanding the unique approach of EFP.

Crossfield Institute (n.d.) is a UK program that provides training and a diploma in The LEAP Method, “the first and only regulated and recognized EFP qualification in the UK specifically for mental health professionals,” (Crossfield Institute, “Home,” n.d.). Few details of the method or requirements are provided on the website.

OK Corral Series (OK Corral, n.d.) offers certification seminars in a variety of concentrations, to include basic EAP and EAL techniques, specific applications for families, veterans, and corporations. Certification in EAP is earned after the first 3-day seminar. There are no requirements to maintain certification once the initial seminar is completed, and no educational prerequisites to take the course. O.K. Corral is based on the work of Greg Kersten,

who the program describes as the founder of EAP as well as EAGALA, the non-profit arm of his first certification business, Equine Services, Inc. Kersten's program is based on the principles of pressure/pain, attention/at-ease, re-circle process, push/pull, and the nonverbal zones.

Eponaquest Worldwide (n. d.) was founded by Linda Kohanov, author of several books on the field of equine therapy. Her program is an apprenticeship program, for which applicants must complete an introductory course as well as additional advanced workshops or have previously graduated from an approved program in order to be considered. Other requirements include having easy access to a horse, five years or 2000 hours of horse experience, previous experience with group dynamics, demonstrate mental and emotional maturity, and be in proper physical fitness. The apprenticeship includes up to four weeks of hands-on experience with Kohanov. Although continuing education opportunities are listed on the website, it is unclear what, if any, are required for certification renewal.

Tables and Figures

Table 1

Frequency of use of EFP

Type of Use	Frequency					Mean
	<u>Never</u> (0)	<u>Sometimes</u> (1)	<u>About half the time</u> (2)	<u>Most of the time</u> (3)	<u>Always</u> (4)	
Stand-alone	6	3	4	2	1	1.3
Supplemented by outside therapy	3	7	3	2	1	1.4
Secondary to psychotherapy provided by participant	3	6	2	3	2	1.7
Secondary to psychotherapy provided by outside provider	2	6	3	4	1	1.8

Table 2

Interventions that are Standard Practice for EFP

<u>Intervention</u>	<u>Count</u>	<u>%</u>
Commenting or reflecting on spontaneous client-animal interactions.	16	100.0%
Allowing the horse to be present without any directive interventions.	16	100.0%
Allowing the horse to engage with the client in spontaneous moments that facilitate therapeutic discussion.	15	93.8%
Reflecting or commenting on client's relationship with the horse.	14	87.5%
Encouraging client to interact with the horse by touching or grooming the horse.	14	87.5%
Observing and discussing horse behavior in the herd.	14	87.5%
Encouraging client to tell therapy animal about client's distress or concerns.	13	81.3%
Creating specific structured activities for a client with the horse.	13	81.3%
Allowing time to process interactions away from the horse.	13	81.3%
Modeling appropriate and safe interactions with the horse.	11	68.8%
Sharing stories and metaphors with equine themes with the client.	10	62.5%
Encouraging client to recreate/reenact experience where the horse plays a specific role.	10	62.5%
Interacting with the horse by having the horse follow commands.	9	56.3%
Using the client-horse relationship, such as, "If [horse] were your best friend, what would he know about you that no one else would know?" And/or "Tell [horse] how you feel and I will just listen."	9	56.3%
Providing rationale for therapeutic work with equines.	9	56.3%
Sharing history of the horse with the client.	8	50.0%
Encouraging the client to make up stories involving the horse.	8	50.0%
Encouraging the client to perform commands with the horse.	7	43.8%
Providing psychoeducation on client's symptoms and how they may present in interactions with the horse.	7	43.8%
Sharing the horse's family history (e.g., lineage, breed, etc.) with the client.	3	18.8%
Other: Asking questions that illicit the client's perspective and interpretation of their own personal story. Facilitators do not interpret what is going on for the client.	1	6.3%
Other: Encourage client to imagine what the horse may be saying to them	1	6.3%

Note: Adapted from O'Callaghan & Chandler (2011)