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Walden University

College of Counselor Education & Supervision

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Mark Mayfield

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Walden University
2016

Abstract

Equine Facilitated Psychotherapy for Veteran Survivors With Full or Partial PTSD

by

Mark Aaron Mayfield

MA, Denver Seminary, 2010

BA, Colorado Christian University, 2004

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

November 2016

Abstract

Symptom severity among veteran survivors with partial or full posttraumatic stress disorder (PTSD) continues to increase, with approximately 40% of U.S. veterans reporting significant symptomology 10 years after initial onset of the condition. Veteran survivors often struggle to find therapeutic interventions that meet their specific needs and have a difficult time maintaining a therapy that is both equitable and evidenced based. Grounded in the Rogerian, client-centered theory, the purpose of this qualitative collective exploratory case study was to explore the effects of equine-facilitated psychotherapy with 3 veteran survivors with partial or full PTSD. A 4-stage process was used to collect data, including initial semistructured interviews, observations, photo-interviews, and researcher interpretations of photo-interviews. Data were transcribed, analyzed, and coded into within-case themes and cross case-themes. The principle findings revealed that veteran survivors with partial or full PTSD engaged in an equine-facilitated psychotherapy program had both here-and-now experiences and relational connection experiences with the horse. Many other significant details provided insight into the veteran participants' experiences with equine-facilitated psychotherapy, such as trust, connection, nonverbal communication, awareness, peace, decompression, communication, empathic reflection, congruence, reciprocity, concern, respect, and selflessness. These findings provide social change implications that may inform mental health professionals and counselor educators about the benefits of equine-facilitated psychotherapy with veteran survivors with partial or full posttraumatic stress disorder; the findings also provide structure to the use of equine-facilitated psychotherapy as an adjunct and/or alternative to traditional posttraumatic stress disorder treatments.

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Dedication

This study is dedicated to my beautiful and supportive wife who has been by my side throughout these past 8 years of school. Without you, none of this could have been accomplished and, without you, none of this would have any meaning!

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First, this study would not have been possible without the constant encouragement and support of my wife and best friend, Sarah Marie Mayfield. Without her by my side, this study would have been much more difficult. Thank you! I would also like to acknowledge the sacrifice she made when we agreed to pursue the PhD. Thank you for standing by my side. Second, I would like to acknowledge my committee, Dr. Laura Haddock, Dr. Kristi Cannon, and Dr. Corrine Bridges, for their expertise and patience with my many revisions. Thank you for your mentorship as you helped me develop into a qualitative researcher. Finally, I would like to acknowledge the time given up by my family at family gatherings, allowing me to study, research, and write throughout this process.

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Chapter 1: Introduction to the Study

Introduction

The prevalence of combat-related posttraumatic stress disorder (PTSD) has continued to rise, as many recently returning veterans report experiencing partial or full symptomology (Lanning & Krenek, 2013). Owing to the real or perceived stigmatic undercurrent of the military, many veterans delay seeking appropriate treatment for fear of being alienated (Kelley, Britt, Adler, & Bliese, 2014), considered weak or incompetent, or blamed for their own problems (Gibbs, Olmsted, Brown, & Clinton-Sherrod, 2011). Though current evidenced-based therapies such as cognitive processing therapy (CPT), prolonged exposure (PE), and eye movement desensitization reprocessing (EMDR) provide a suitable framework through which appropriate help can be received, there appears to be a gap in treatment efficacy with as many as 40% of veterans reporting significant symptoms 10 years after initial onset (Sharpless & Barber, 2010). Therefore, to enhance the positive therapeutic outcomes for veteran survivors with PTSD, research must explore the potential therapeutic alternatives.

In recent years, equine-assisted activities and therapies (EAA/T), including equine-facilitated psychotherapy (EFP) have continued to grow as an alternative and/or adjunct to traditional modalities (Bachi, 2012; Burgon, 2013; Ewing, MacDonald, Taylor, & Bowers, 2007). Though many research studies explore the efficacy of EAA/T, much of the equine literature focuses on the use of the therapy among people with disabilities (Drnach, O'Brien, & Kreger, 2010; Snider, Korner-Bitensky, Kammann, Warner, & Saleh, 2007; Tseng, Chen, & Tam, 2013), individuals diagnosed with autism spectrum disorder (Kern et al., 2011; Memishevikj & Hodzhikj, 2010), and children survivors of emotional, mental, and cognitive disorders (Burgon, 2013; Cuypers, DeRidder, & Strandheim, 2011; Johansen, Arfwedson Wang,

Binder, & Malt, 2014). However, limited research exists on the interaction between EFP among veteran survivors with partial or full PTSD. I contributed to the body of academic literature on alternative treatment modalities, specifically for veteran survivors with PTSD.

This chapter will include the gap in the current literature, problem statement, purpose statement, and research questions. The theoretical foundation for this study were the client-centered theory as espoused by Rogers. I conclude the chapter with a brief description of the nature of the study, definitions, assumptions, limitations, delimitations, and significance.

Background

Military conflicts, such as Operation Iraqi Freedom (OIF) in Iraq and Operation Enduring Freedom (OEF) in Afghanistan, have been the focal point in both media and political venues for military operations during the past decade (Erbes, Curry, & Leskela, 2009). In recent times, these conflicts have captivated much of the world's attention. The severity of the emotional and psychological effect has been significantly underreported due to the negative stigma associated with mental health treatment modalities (Held & Owens, 2013). According to Sharpless and Barber (2011), veterans reporting PTSD symptoms increased nearly 80% from 1999 to 2004, growing from 120,265 reported cases to 215,871 reported cases. Confirming the growth in reported PTSD cases, the Department of Veterans Affairs (VA) indicated that of the 347,750 men and women who have served in OIF/OEF, 42.5% were diagnosed with some form of mental disorder, the VA's second highest diagnosis (Erbes et al., 2009). Monson et al. (2006) posited that the conflicts in Iraq and Afghanistan are "creating a new generation of veterans with high levels of PTSD and related mental health symptoms" (p. 898).

According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th edition) (*DSM-5*), PTSD is characterized by the experience of a traumatic exposure (e.g., near death

experience, actual or threatened violence, injury, and/or actual or threatened sexual violence). Furthermore, traumatic exposure is consistently re-experienced, there is an effort to persistently avoid distressing trauma-type stimuli, and there is a direct impact on daily functioning (American Psychiatric Association, 2013). Boden et al. (2013) stated that the current understanding of PTSD suggests that it is a disorder of “experiential and emotional avoidance” (p. 298). Veteran survivors with partial or full PTSD symptomology will often overuse emotional suppression to avoid reliving the unpleasant and/or adverse emotional experiences thus complicating the problem (Boden et al., 2013).

Traditional therapeutic interventions attempt to focus on either cognitive behavioral therapy (CBT), PE, or EMDR (Lefkowitz et al., 2005). Even though these therapeutic practices are evidenced based, the therapeutic dissatisfaction remains high with recidivism rates reported as high as 40% (Sharpless & Barber, 2011). Erbes et al. (2009) indicated that the “provision of timely and effective care for postdeployment mental health disorders, including PTSD, remains an important priority” (p. 176). In reaction to the aforesaid recidivism rates of conventional and/or traditional therapeutic modalities, researchers have begun to explore the potential experiential alternatives. Within the archetype of animal-assisted therapy (AAT), EFP is continuing to grow as a viable experiential alternative to traditional therapeutic modalities (Bachi, 2012; Ewing et al., 2007). Idealistically, EFP functions out of the experiential triadic relationship manifested among the client, the therapist, and the equine (Ewing et al., 2007). In this relational engagement, there is an inimitable experiential exchange that cannot be equally replicated in conventional and/or traditional psychotherapy (Trotter, Chandler, Goodwin-Bond, & Casey, 2008).

Animal-Assisted Therapy

AAT is defined as the process whereby animals are directly integrated into the therapeutic environment and processes (Chandler, Portrie-Bethke, Minton, Fernando, & O'Callaghan, 2010). This complementary intervention has the potential to unify itself with a myriad of cognitive, behavioral, psychosocial, physiological, and physical therapies (Chandler et al., 2010; Marcus et al., 2013). The animal functions within a collaborative partnership, with the therapist, to provide a friendly, nonjudgmental, compassionate, and stimulating emotional bridge to the therapeutic alliance (Chandler et al., 2010; Kemp, Signal, Botros, Taylor, & Prentice, 2014).

Research has tested, explored, and experimented with the efficacy of AAT interventions among individuals suffering from pervasive development disorders, cerebral palsy, speech disorders, cardiovascular disease, depression, schizophrenia, Alzheimer's disease, cancer, spinal cord injuries, rehabilitation centers, and nursing homes (Marcus et al., 2013). The literature has indicated that AAT interventions produce tangible health changes in cardiovascular stress, a decrease in systolic and diastolic blood pressure, improvements in neurological stress markers, and in an increased production of neurotransmitters such as endorphins and dopamine (Aoki et al., 2012; Marcus et al., 2013). In addition to the health benefits, AAT has demonstrated significant improvement in emotional affect and attunement, depressive symptoms, socialization, enhancing self-esteem, and enhancing overall psychophysiological health (Chandler et al., 2010).

Though decades of research have demonstrated the efficacy of AAT, there has still been a significant lack of a unified theoretical framework (Geist, 2011). Subsequently, with the advent of evidenced-based practices, AAT has struggled to position itself as a legitimate alternative to traditional therapies (Geist, 2011). This dilemma is magnified within the research as studies

continue to struggle to use appropriate sample sizes, diverse populations, and controlled studies (Marcus, 2013).

Equine Therapies

Within the structure of AAT, equine-assisted therapies (EATs) are continuing to grow as a viable experiential alternative to traditional therapeutic modalities (Bachi, 2012; Ewing et al., 2007). Previous and current research endeavors have focused primarily on the effects of therapeutic horseback riding and hippotherapy (HPOT) among individuals diagnosed with autism spectrum disorders (Bass, Duchowny, & Llabre, 2009; Tseng et al., 2013). Kern et al. (2011) indicated that individuals participating in therapeutic horseback riding have significantly improved in language skill development, sensory integration, and social acumen. Furthermore, research has also explored the effects of equine-assisted learning (EAL) on adolescents diagnosed with emotional disorders (Ewing et al., 2007).

EFP, a psychotherapeutic component of EAT, is defined by the Professional Association of Therapeutic Horsemanship International (PATH International), which stated:

> EFP is an interactive process in which a licensed mental health professional working with or as an appropriately certified equine professional, partners with suitable equines to address psychotherapy goals set forth by the mental health professional and the client. (PATH International, 2012, para. 4)

Operating within a triadic framework, EFP relies on the experiential interaction of the client, therapist, and equine (Ewing et al., 2007). Horses are prey animals, which allows them to function as sentient beings (e.g., the ability to attune to the emotional states of others, read/feel body language, and give and receive emotions) (Kemp et al., 2014; Selby & Smith-Osborne, 2013). It is through this relational reciprocity that the horse is able to directly contribute to the

client's experiential processes and subsequent gains therein (Kemp et al., 2014; Selby & Smith-Osborne, 2013).

The EFP model intentionally focuses on the here and now processes of the therapeutic session (Selby & Smith-Osborne, 2013). This focus allows for the immediate experiential processing of cognitive, affect, behavioral, and sensory functioning (Selby & Smith-Osborne, 2013). Within this therapeutic paradigm, the horse provides a warm, patient, receptive, and cooperative environment (Lentini & Knox, 2008). Through this genuine relational interchange, the substantial potential for positive growth is fostered (Lentini & Knox, 2008; Selby & Smith-Osborne, 2013)

Within the existing research, Kemp et al. (2014) studied 30 sexually abused children from a local treatment center. Using tools such as the Children's Depression Inventory, the Child Behavioral Checklist, the Beck Depression Inventory, and the Beck Anxiety Inventory, the authors found significant improvement in scores with robust effect sizes of .702 to .905 among the adolescent population, and .583 to .880 among the child population (Kemp et al., 2014). Cantin and Marshall-Lucette (2011) provided a literature review of five qualitative and mixed-methods studies focusing on the utilization of EAT with mentally disturbed and/or abused children. The authors found that EAT is a viable experimental therapy that positively enhances all aspects of mental health (Cantin & Marshall-Lucette, 2011).

Expanding the depth of research, Trotter et al. (2008) conducted a comparative study with at-risk youth. The study used a nonrandom convenience sample of students at risk of suspension or expulsion owing to academic failure (Trotter et al., 2008). The sample consisted of 164 (n = 164) participants: 126 (n = 126) were assigned to equine-assisted counseling and 39 (n = 39) were assigned to a school based intervention (Trotter et al., 2008). Using the Behavioral

Assessment System for Children and the Psychosocial Session Form, the results demonstrated statistically significant improvements in 17 behavior areas whereas the school-based intervention showed only 5 statistically significant improvements (Trotter et al., 2008). Selby and Smith-Osborne (2013) conducted a meta-analysis of the equine therapies literature using the Grading of Recommendations Assessment, or GRADE, criteria. Of the 103 articles initially chosen, only 14 met the criteria (Selby & Smith-Osborne, 2013). Four were pilot studies, four were comparison pre/posttest design, two were program evaluations, one was an experimental study, one was a single-group observational study, and two were pre/posttest designs with follow-up protocol (Selby & Smith-Osborne, 2013). Not one of the selected articles focused on military personnel and/or PTSD. Consequently, based on the literature that has been examined, there have been minimal resources identified that focus on the effectiveness of EFP with veteran survivors with PTSD.

Problem Statement

Approximately 40% of veteran survivors with PTSD report significant symptomology 10 years after the initial onset of the condition (Lefkowitz et al., 2005; Sharpless & Barber, 2011). After conducting a thorough search of the literature, multiple identified studies explored the efficacy of EFP and related therapies within a variety of contexts. However, there was limited research designed to understand effect of EFP as an experiential alternative to traditional therapy with veteran survivors with PTSD. Counselors and counselor educators potentially have limited, lacking, and/or outdated treatment options for this new veteran generation. As a result, of this limited information, counselors and counselor educators struggle to provide evidenced-based, alternative experiential care for the growing veteran population and their families. I sought to understand the lived experiences of veteran survivors with PTSD engaged in an EFP program.

Purpose of the Study

The purpose of this qualitative collective exploratory case study was to discover the effects of EFP with veteran survivors with partial or full PTSD. I used the exploratory case study approach to document the experiences of the veteran participants involved in an EFP program. Veteran survivors with partial or full PTSD can often struggle to find quality, comprehensive treatment that meet the specific needs of combat related PTSD. I attempted to shed light on the possible use of EFP as an alternative and/or adjunct to traditional therapy. My findings may be used to inform professional counselors and others in the helping profession about the therapeutic experiences of veteran survivors with partial or full PTSD.

Research Questions

Fundamental to the success of a qualitative collective exploratory case study inquiry is the specifically formulated questions therein. Creswell (2009) indicated that within a qualitative inquiry the research question can have two specific forms, the central question(s) and the associated subquestions.

Central Question

What are the experiences of veteran survivors with PTSD who use EFP for their recovery?

Subquestions

1. How do veteran survivors with PTSD describe their experiences with EFP?
2. Does EFP benefit the recovery of veteran survivors with PTSD?
3. How do veteran survivors with PTSD describe the effects of EFP toward their recovery?
4. What treatments have veteran survivors with PTSD experienced prior to EFP?

Framework

The integration of a theoretical and/or conceptual framework is critical for the direction

and success of a qualitative collective exploratory case study research inquiry (Creswell, 2009). Fundamentally, the theoretical perspective functions as a foundational premise through which the overall effectiveness of the qualitative study can be properly evaluated (Creswell, 2009). Furthermore, within the context of research, theory informs practice, thus providing a structured lens through which research is developed and understood (Rudestam & Newton, 2007). Owing to the fledgling nature of EFP and the lack of effectual theories therein, I sought to use the Rogerian Person-centered approach as the main theoretical construct.

Within the therapeutic exchange, the Rogerian or client-centered approach to counseling focuses primarily on relational development (Tudor & Worrall, 2006). This nondirective approach engages the client by reflecting back both verbal and nonverbal communication while encouraging the client to take steps towards self-acceptance and self-actualization (Chandler et al., 2010). Aligning with the principles of EFP, the person-centered approach chooses not to manage the client but rather attempts to create an environment that is nonjudgmental, warm, accepting, and empathic (Chandler et al., 2010; Williams & Irving, 1996). Through these established therapeutic relational parameters, the client is able to focus on the here-and-now, relinquish the skewed representations of the past, and begin to create/develop a deeper sense of self (Chandler et al., 2010).

Nature of Study

Qualitative research is a highly effective way through which the world can be explored and explained. However, Creswell (2013) indicated that qualitative research has been criticized inasmuch as it often appears to be lacking empirical support through which to effectively validate the quality and reliability therein. It is essential that the qualitative researcher explore the rigorous methods involved, so that a symmetrical analysis can be provided (Creswell, 2013).

Furthermore, the researcher must be cognizant of his or her credibility, implore the utmost integrity, and use critical reasoning in all aspects of the research (Creswell, 2013).

A case study is an empirical inquiry that seeks to answer the *how* and *why* of a contemporary phenomenon within the undisturbed, real-world context of the specified participants (Stake, 2006; Yin, 2014). Because little research exists on EFP in relation to its use with veteran survivors with PTSD, this research intended to explore the effectiveness (or lack therein) of EFP through the investigation and observation of the experiences of veteran survivors with PTSD involved in EFP (Baxter & Jack, 2008)

Within the parameters of a case study, the researcher must consider several key components. First, the researcher needs to be focused on the *how* and *why* questions of the inquiry (Baxter & Jack, 2008). Second, the researcher must understand that a case study is not a different type of fieldwork (e.g., ethnography, participant-observation) (Baxter & Jack, 2008; Yin, 2014). Third, there is an innate importance to focus on the holistic, real-world representation of the case, without manipulation (Stake, 2006; Yin, 2014). Finally, the case must be effectively bound to time and place; time and activity; and definition and context (Baxter & Jack, 2008).

As has been previously discussed, I explored the experiences of veteran survivors with PTSD as they interacted within the structure of EFP. The purpose of the research was to understand whether and/or how and why the experience of EFP changed and/or altered the PTSD symptomology. The data received for this project consisted of semistructured interview, observation (e.g. complete observer), and a photo-interview. I took notes during the interview(s) and the interview(s) were recorded, transcribed, and coded.

Definitions

Animal-assisted therapy. AAT is a complementary intervention developed by Levinson in the early 1960s. This therapeutic intervention is conducted by a trained human service provider (e.g., mental health professional, health professional) and a certified animal (typically a dog) (Dietz, Davis, & Pennings, 2012).

Combat-related PTSD. In addition to the *DSM-5* criteria for PTSD, combat-related PTSD is developed through time and with repeated exposure to direct combat and/or threat of direct combat (Fragedakis & Toriello, 2014). These chronic threats of harm resulted in both complex psychological and physiological symptoms.

Descriptive case study. A descriptive case study attempts to describe the phenomenon of study in its real-world context (Yin, 2014).

Equine-Assisted Growth and Learning Association. The Equine Assisted Growth and Learning Association (EAGALA) was founded in 1999 with the desire that "every person worldwide will have access to these therapy services" (EAGALA, 2010, para. 1). EAGALA is considered to be the "leading international nonprofit association for professionals using equine therapy (horse therapy) to address mental health and human development needs" (EAGALA, 2010, para. 1). Like PATH International, EAGALA certifies centers and trains individuals to provide both equine-assisted psychotherapy (EAP) and EAL.

Equine-assisted learning. Operating from a similar structure as EAP, EAL focuses specifically on the learning and/or educational goals of the client rather than the mental and/or behavioral goals (EAGALA, 2010).

Equine-assisted psychotherapy. EAP experientially integrates the horse into the therapeutic setting. This is accomplished through the intentional collaborative effort between the

horse, the licensed mental health professional, and the client. EAP is a short-term, experiential, goal oriented approach whereby the therapist, and the horse, aid in the mental and behavioral growth of the client (Trotter et al., 2008).

Equine-facilitated psychotherapy. EFP is the interactive process through which a licensed mental health professional works with or is credentialed as an equine professional, partners with an equine to work towards pre-established therapy goals collaboratively determined by the mental health professional and the client (PATH International, 2015).

Hippotherapy. HPOT is a physiologic modality that is typically performed with one rider, one therapist (e.g., physical therapist, occupational therapist, and/or speech-language pathologist), and a horse (Granados & Agis, 2011). The premise of HPOT is to use the three-dimensional movement of the horse to manipulate the body movement of an individual with a physical disability (Granados & Agis, 2011).

Person-centered theory. Person-centered theory was developed by Rogers and is a nondirective approach whereby the therapist reflects, clarifies, and directs client communication (verbal and nonverbal) (Chandler et al., 2010). The goal of person-centered therapy is to enhance the client's insight, thus promoting the development of greater self-actualization (Chandler et al., 2014).

Posttraumatic stress disorder. The diagnostic criterion for PTSD is characterized by the (a) presence of intrusive symptoms, including recurrent and distressing memories or flashbacks; (b) efforts to avoid stimuli associate with the event; (c) negative changes in thoughts, and mood, including suppression of memories associated with the event, cognitive distortions and exaggeration of negative beliefs, and withdrawal and detachment behaviors; and (d) changes in arousal and reactivity, including hypervigilance, recklessness, and increased irritability and anger

(American Psychiatric Association, 2013). The aforementioned symptomology must be experienced for at least 4 weeks.

The Professional Association of Therapeutic Horsemanship International. PATH International was formed in 1969 as the North American Riding for the Handicapped Association (NARHA) as an attempt to promote EAA/T (PATH International, 2015). Currently, PATH International has certified over 4500 instructors and equine specialists and has accredited more than 850 centers around the world (PATH International, 2015). Each year, approximately 58,300 children and adults with cognitive, physical, and emotional disabilities are impacted through the use of HPOT, TR, and/or EFP (PATH International, 2015).

Therapeutic riding. Therapeutic riding (TR) is a component of equine therapy that focuses on teaching the client to properly ride the horse, thus improving coordination, postural control, balance, etc. (Drnach et al., 2010).

Veteran. In this study, the term *veteran* was used to describe any individual who has served in the military.

Assumptions

When employing a qualitative approach to research, several basic assumptions are present. First is the philosophical worldview of social constructivism. This philosophical assumption emerged in the late 1960s and developed through the 1980s (Creswell, 2009). This assumption believes “that individuals seek understanding of the world in which they life” (Creswell, 2009, p. 8). Individuals create subjective meaning from experience, thus allowing the research to develop a multiplistic understanding of the studied phenomena (Creswell, 2009). Second, and similar to social constructivism, the researcher explored the meaning of the studied phenomena as it is understood by the participant in their natural setting (Arghode, 2012). The

third basic assumption is that of interpretivism. Interpretivism, as explained by Schwandt (2001), connotes that the “meaning of human action is inherent in that action” (p. 160). Therefore, I attempted to uncover the inherent meaning through the act of in-depth analyzing and exploring (Arghode, 2012). These assumptions point to the fact that qualitative research is an inductive, fluid process, whereby meaning is continually sought after, discovered, and shaped by the reciprocal relationship of the participant(s) and the researcher.

When applied to veteran survivors with PTSD, several more assumptions emerged specific to symptomology and perception. The first assumption is that all veterans experience trauma in the same way; this is not true (Albright & Thyer, 2010). Owing to the complexity of the human body, individuals faced with the same type of trauma will physiologically, cognitively, and emotionally experience it differently (Frommberger, Angenendt, & Berger, 2014; Koenen, 2010). This understanding was significant to this study in several ways. First, the way a veteran experiences trauma is unique to his or her culture and physiological makeup. Second, not all veterans will express the same *DSM-5* symptomology and/or experience these symptoms in the same way. Third, it should not be assumed that all military personnel struggle to express themselves emotionally. Instead, there needs to be a depth of understanding regarding the innate culture of the military and the subsequent emotional expression therein.

A second assumption I made in this study was that not all military believe that treatment is ineffective. Though this has been an expressed stigma and perception by many, the military has a wealth of services available to both active-duty and veteran members (Borah et al., 2013; Margolies, Rybarczyk, Vrana, Leszczyszyn, & Lynch; Monson et al., 2006; Possemato et al., 2011; Tuerk et al., 2011). Therefore, the military should not be viewed as the antagonist, but rather as an integral piece of this complex puzzle.

Scope and Delimitations

The scope of this current study was defined geographically to three major cities along the Front Range of Colorado (i.e., a geographical area that runs the entire length of Colorado, along the foothills of the Rocky Mountains). Owing to the specific nature of this study, I focused on equine-assisted centers were including those that used EAA/T, specifically EFP with veterans.

A delimitation of this study was the operational definition of *EFP*. For the purpose of this study, EFP included equine-assisted psychotherapy/therapy (EAP/T) and EAL, as outlined by EAGALA and PATH International. Another delimitation was the participants' understanding of PTSD. Therefore, a prescreening assessment was given the participants' to simply understand the scope of PTSD (e.g., partial or full symptomology). In addition, the limited scope of EAA/T, and the lack of a universal therapeutic definition, this study did not apply to equine therapies and veterans in general. Rather this study and the trustworthiness therein was described by the researcher to aid the development of future research.

Limitations

Strengths and limitations are inherent within every framework. Several limitations existed in this current design. First, owing to the geographical limitations and scope of this study, the information that I gathered may not be generalizable to the broader veteran population. Second, interview responses from veteran participants may have be influenced by extraneous variables (e.g., mood, circumstances of the day, external therapies, medications). Third, I made observations only during one of the EFP sessions and I did not consider previous sessions. Fourth, there was a lack of ability to differentiate between trauma experienced in combat and trauma experienced outside of combat.

Another significant limitation was the role of researcher bias. I grew up owning horses, and I have worked with horses in a number of different therapeutic ways (e.g., HPOT, therapeutic riding, and EFP with children and adolescents). Though researcher bias is an accepted axiological premise in qualitative research, it should in no way alter the results of the study. To ensure that bias did not affect this study, I used strategies such as prolonged engagement, the triangulation of data, member checks, reflexive journaling, thick and rich descriptions, and self-exploration (Creswell, 2009; Yin, 2014).

Significance

Owing to the lack of PTSD treatment diversity, and the minimal qualitative research on EFP with the veteran population, the purpose of this study was to explore the perceptions of veterans and treatment providers involved in EFP as an experiential alternative and/or addition to traditional therapeutic modalities when treating veterans with partial or full PTSD. My goal was to begin to understand the effectiveness of EFP from the perspective of the veteran participants' lived experiences.

With a new generation of veteran survivors with PTSD reintegrating into society, it is crucial that current and/or new therapeutic modalities are implemented in an effort to provide proper care (Monson et al., 2006). Therefore, I sought to provide insight into the possible use of alternative experiential therapies for veteran survivors with PTSD. Potential outcomes might include the increase of coping skills, the reduction of suicidality, and the improvement of overall functioning and quality of life. Furthermore, this study would hope to expand/increase the evidenced-based viability of EFP as an alternative and/or addition to traditional therapies.

Summary

With the continuance of military conflicts around the world, PTSD remains a consequence of the trauma experienced. Though research has shown the benefits of evidenced based treatments, there was still a large subset of the population that is falling through the cracks. Alternative therapies, such as EFP, have grown in prevalence and have yielded positive results within diverse populations. However, there have been minimal studies that explore the effects of EFP with veteran survivors with partial or full PTSD.

My intention in this collective exploratory case study was to collect, describe, and interpret the experiences of the veteran survivors engaged in an EFP program. This study benefited the field of counseling inasmuch as it provides an understanding of an alternative therapeutic modality, thus potentially enriching the lives of the veterans. Furthermore, this research can add to the growing literature on equine therapies, thus bringing continuity to the therapy, developing operational definitions, and enhancing future research.

Chapter 2 contains history of PTSD, a review of the literature on veteran survivors with PTSD, current models of therapeutic interventions, and an in depth expose on AAT, including EAA/T. In Chapter 3, I discuss the research design and format. Chapter 4 contains the results of the study, and Chapter 5 contains the interpretations and conclusions of the study.

Chapter 2: Literature Review

Introduction

Approximately 40% of veteran survivors with PTSD report significant symptomology 10 years after the initial onset of the condition (Lefkowitz, Paharia, Prout, Debiak, & Bleiberg, 2005; Sharpless & Barber, 2011). After conducting a thorough search of the literature, I identified multiple studies that explored the efficacy of EFP and related therapies within a variety of contexts. However, limited research is designed to investigate the effect of EFP as an experiential alternative to traditional therapy with veteran survivors with PTSD. Counselors and counselor educators have potentially limited, lacking, and/or outdated treatment options for this new veteran generation. As a result of this limited information, counselors and counselor educators struggle to provide evidenced-based, alternative experiential care for the growing veteran population and their families. The purpose of this exploratory case study was to understand the lived experiences of veteran survivors with PTSD engaged in an EFP program. My goal was to begin to understand the effectiveness of EFP from the perspective of the veteran participants' lived experiences.

With a new generation of veteran survivors with PTSD reintegrating into society, the implementation of current and/or new therapeutic modalities is crucial to provide proper care (Monson et al., 2006). Therefore, this study will potentially provide insight into the possible use of alternative experiential therapies for veteran survivors with PTSD. Prospective outcomes of this study might include the increase of coping skills, reduction of suicidality, and improvement of overall functioning and quality of life. Furthermore, my premise was to expand/increase the evidenced-based viability of EFP as an alternative and/or addition to traditional psychotherapies.

In this chapter, I focus on three main sections, with several subsections therein. First, I discuss the etiology, epidemiology, and effects of PTSD in the broader population. Second, I explore a historical overview of mental health problems with combat veterans, showing the continued need for psychotherapeutic interventions. Third, I examine the barriers of treatment, the stigmas associated with mental health diagnoses, and the difficulties in assessing for PTSD due to comorbid conditions. Finally, I provide an overview of the current evidence-based treatments for combat-related PTSD in relation to engagement and effectiveness, thus laying the foundation for the discussion for the possibilities of alternative/adjunct interventions, such as EFP.

The second section includes the inherent theoretical perspective within this dissertation as a foundational premise to the overall effectiveness of a qualitative exploratory case study approach. The Rogerian or person-centered approach to counseling was discussed in relation to the therapeutic relationship and subsequent progression of the therapeutic progress therein. I compared research on the key concepts of the person-centered approach , and I explored the therapeutic effectiveness and the unique factors that contribute to change.

In the third section of this chapter, I focus on AAT, and then specifically on EFP/EAP. First, I review the historical perspective of AAT. Second, I discuss the use of equine therapies (therapeutic riding, HPOT, etc.). Finally, I explore the growth of EFP/EAP in relation to current uses with children, adolescents, people with addictions, and military populations.

Literature Search Strategy

I implemented several modalities in the search for relevant literature for this dissertation. The main databases that I searched were EBSCOhost, SAGE, MEDLINE, ProQuest, and PsycINFO. The search terms covered several categories that encompassed the totality of the

topics covered in this dissertation. Categories included individual terms such as *posttraumatic stress disorder*, *PTSD*, *combat-related PTSD*, *mental health stigma*, *veterans and PTSD*, *etiology of PTSD*, and *treatment of PTSD with veterans*; *person-centered therapy*, *Rogerian theory/therapy*, and *self-actualization theory*; and *equine facilitated psychotherapy*, *equine assisted psychotherapy*, *hippotherapy*, *animal assisted therapy*, *therapeutic riding*, *animal assisted therapy and veterans*, and *equine therapy*. Additional searches focused on qualitative approaches, specifically case study, phenomenological, descripted approaches; ProQuest dissertation searches; and cross-discipline searches (e.g. nursing literature, medical literature).

Theoretical Foundation: Client-Centered Theory

Theory Description and Origin

Client-centered therapy, also known as person-centered therapy or the Rogerian model, was a theoretical construct that developed out of the person and work of Carl Rogers. Influenced by the Philadelphia School of Social Work, Rogers (1951) credits the roots of his newer psychotherapy to the work of individuals such as Otto Rank, Jessie Taft, Frederick Allen, and Virginia Robinson. Prior to the development of his newer approach, Rogers was shaped heavily by his practical experiences as a developing psychologist (Thorne, 2013). He initially spent twelve years of his career at the Child Study Department of the Rochester Society for the Prevention to the Cruelty to Children (Thorne, 2013). During his tenure in Rochester, Rogers realized that the previously prescribed theories and techniques of his schooling significantly failed to meet the present needs of his clients (Thorne, 2013). It was during this time that Rogers began to formulate his foundational understanding of the key attitudes of an effective therapist (Thorne, 2013). Rogers concluded that an effective therapist should display an objectivity with a

client, a respect for the client, an understanding of self, and a fundamental knowledge of human behavior (Thorne, 2013).

In 1939, Rogers was offered a fully professorship at Ohio State University where he was provided the opportunity to take an active role in the innovation of a new framework (Kensit, 2000; Thorne, 2013). During his time at Ohio State University, Rogers was invited to lecture at the University of Minnesota where he spoke on the *Newer Concepts in Psychotherapy*, thus officially marking the birthplace of client-centered psychotherapy (Thorne, 2013). In the early stages of his research, Rogers concluded that only clear, supportive, and accurate reflections were necessary for client change (Rogers, 1942). He stressed that therapy should be less about solving the client's problems and more about aiding the client's growth and development, thus allowing for a more integrated and interactive response to life (Thorne, 2013).

Upon completion of his four years at Ohio State University, Rogers was invited to open up a counseling center at the University of Chicago (Thorne, 2013). His twelve years in Chicago proved to be his most creative and productive years as he published two of his most influential works, *Client-Centered Therapy* and *Psychotherapy and Personality Change* (Thorne, 2013). Rogers' therapeutic views expanded from his time at Ohio State University from simple a reflective stance of the counselor, to a belief that the counselor's attitude about the clients' feelings and potential change played an important role into the change itself (Kensit, 2000). The counselor still maintained a non-directive therapeutic stance, but when necessary could speak into specific client expressed frames of reference (Kensit, 2000).

An overarching theme of Rogers' approach was his innate skepticism of theories in general. Rogers postulated that the premature utilization of a theoretical model had the potential to disrupt the counselor's intuition (Thorne, 2013). Instead of relying on a theory, the counselor

must seek to understand the specific phenomenology of the client and his or her subjective realities therein (Kensit, 2000; Thorne, 2013).

Theoretical Assumption and Framework

Through the development of the client-centered approach, several key assumptions developed. First was the client's phenomenology, constructive reality, or subjective experience (Kensit, 2000). Borrowing from multiple reality theory, Rogers viewed the client experience as unique, and as such no other human being had the ability to fully insert him or herself into their experience. Moreover, the client is the only one who can determine what a correct or incorrect behavior is (Kensit, 2000). The second assumption of client-centered approach is that the individual's thoughts, feelings, and behaviors are driven by the innate desire/tendency for self-actualization (Bozarth, 1997). Self-actualization is the process whereby the client moves from a state of heteronomy (being controlled by external forces) to a state of autonomy (controlled by inner forces) (Kensit, 2000). Rogers espoused that pathologies and disorders arose from the incongruence and inflexibility between an individual's heteronomy and autonomy (Kensit, 2000).

These basic assumptions lay a foundation for the extrapolation of several key characteristics and conditions of the client-centered approach. First, the use of the client-centered approach encourages clients to move towards an integrative independence, rather than merely solving a problem (Lux, 2010; Tudor, 2010). Second, it focuses the client on the here-and-now, rather than getting stuck in the cognitive/intellectual nuances of the past. Third, the client-centered approach focuses on the power of the therapeutic relationship and its inherent growth potential (Bozarth, 1997). To bring about this ideal therapeutic structure, the client-centered

approach uses congruence, empathy, and unconditional positive regard as a basic framework (Lux, 2010).

Congruence. Becoming a fully functional organism or a self-actualized individual, the client must learn to become more congruent with self. According to Lux (2010) this is portrayed through an accurate understanding of the client's lived experiences, and the proper integration therein. Practically, the client must have an openness to his or her experiences and stay connected and attentive to the details of the experience as it happens within and/or to them (Lux, 2010).

Empathy. Empathy is the benchmark of client-centered therapy and undergirds the specific therapeutic processes and outcomes. Rogerian empathy is often thought of as the glue that integrates both congruence and unconditional positive regard. Bozarth (1997) suggests that empathy "exists within a context of non-directivity and is predicated on the foundation block of the actualizing tendency" (p. 83). Bozarth (1997) continued by espousing that the empathic exchange is vital to the therapeutic change process. However, this change can only transpire if the therapist experiences a true empathic connection and demonstrates true unconditional positive regard (Bozarth, 1997).

Rogers (1959) simply defines empathy by stating, "it means to sense the hurt or the pleasure of another as he senses it and to perceive the causes thereof as he perceived them, but without ever losing the recognition, that it is as if I were hurt or pleased" (p. 210). Functionally, empathic understanding means that the counselor is able to see and sense the projected emotions of the client while simultaneously determining the specific cognitive representations (Lux, 2010). The counselor then is able to communicate these realizations back to the client in both verbal and nonverbal ways, thus enhancing the client's ability to recognize and understand his or

her emotions (Lux, 2010). This empathic exchange must be thought of as an essential construct, rather than simply an adjunct to other therapies; embody the therapeutic attitude rather than just a behavior within therapy; and be a non-directive relational process (Bozarth, 1997).

Unconditional positive regard. Perhaps the most widely known component of the client-centered approach is what Rogers called unconditional positive regard. Closely linked to empathy, unconditional positive regard is squarely based on the counselor's attitude and perception of the client (Bozarth, 1997). Simply, the counselor accepts the totality of the client's feelings, emotions, cognitions, and experiences just as they are and without judgment (Lux, 2010). Unconditional positive regard is characterized by compassion, warmth, acceptance, non-judgment, respect, admiration, etc. between the counselor and the client (Lux, 2010).

Literature and Research Based Rationale

Research focused on the extrapolation of a theoretical paring with AAT is significantly lacking. Though the client-centered approach is highly regarded as effective, paring it with animal and/or EFP is nearly non-existent. Chandler et al. (2010) briefly explore the potential use of person-centered counseling with AAT. The authors indicated that AAT is able to seamlessly integrate with the person-centered approach for several reasons. First, the person-centered approach does not manage or direct the session, but rather focuses on the reflection of the client's feelings, emotions, and cognitions as he or she moves towards greater self-acceptance and self-actualization (Chandler et al., 2010). Second is the emphasis on the counselor-client relationship, its impact on the therapeutic process, and the subsequent change therein (Chandler et al., 2010).

Similar connections were made between the person-centered approach and the use of animals in Chardonnens' (2009) study. Chardonnens (2009) explored the use of animals as co-

therapists on a farm, utilizing the person-centered framework for a basis of change. She espouses that the human-animal bond can be a strong relationship, especially with children who have experienced some form of trauma. Using a horse to facilitate a therapeutic session can be an essential tool to entering an authentic relationship (Chardonnens, 2009). The horse is able to maintain a person centered stance inasmuch as it provides a non-judgmental and unconditional framework for acceptance (Chardonnens, 2009). Furthermore, the client must approach and interact with the horse in an authentic and congruent manner. If this is not accomplished, the horse will not enter into an authentic relationship with the client. Only when the client is able to work out the inconsistencies in the here-and-now, will the horse reengage (Chardonnens, 2009).

Current Utilization

This present study described and explored the interaction between EFP and veteran survivors with PTSD. The client-centered framework provided a non-judgmental and non-invasive approach to therapy that invited the client into an authentic working relationship. Similarly, AATs (specifically EFP) are able to build rapport with the client, enhance trust, and facilitate a safe environment. This mirrors the client-centered emphasis of the counselor-client relationship through the use of empathy and unconditional positive regard. Similar to the client-centered focus on the development of insight through the reflection of cognitions and feelings, is the here-and-now focus of EFP. The here-and-now stance of EFP encourages the client to reflect feelings by remaining engaged and congruent with the animal. Furthermore, by remaining in the here-and-now, the client is able to develop an innate self-awareness, grow in self-confidence, and move toward self-actualization.

Literature Review

Posttraumatic Stress Disorder

Etiology of PTSD.

Diagnostic Criterion. According to the Diagnostic and Statistical Manual of Mental Disorders (5th ed.), the individual must experience a traumatic event (e.g. near death experience, actual or threatened violence, injury, and/or actual or threatened sexual violence). The diagnostic criterion for PTSD is characterized by the: (a) presence of intrusive symptoms, including recurrent and distressing memories or flashbacks; (b) efforts to avoid stimuli associate with the event; (c) negative changes in thoughts, and mood, including suppression of memories associated with the event, cognitive distortions and exaggeration of negative beliefs, and withdrawal and detachment behaviors; and (d) changes in arousal and reactivity, including hypervigilance, recklessness, and increased irritability and anger (American Psychiatric Association, 2013, pg. 271-72). The aforementioned symptomology must be experienced for the duration of at least four weeks.

Etiology. PTSD is one of the few mental disorders with a distinct etiology (Peterson et al., 2011). As referenced in the aforementioned diagnostic criterion, PTSD is specifically caused by the personal or proximal exposure to a traumatic event. Though there are a number of distinct factors that can contribute to the severity and/or longevity of the symptoms, it is key to note that with the absence of trauma, PTSD cannot develop (Peterson et al., 2011). With the distinct exposure to a singular and/or multiple traumas, PTSD can manifest as a persistent illness with profound effects on the individual struggling with its adverse symptomatology (Possemato et al., 2011). These adverse effects can be so pervasive that even after an individual recovers from the active symptoms, they still might face functional impairment due to subsyndromal or better

known as partial PTSD (e.g. meeting only partial diagnostic criteria for PTSD) (Possemato et al., 2011).

Initially, the term subsyndromal/partial PTSD was used to describe Vietnam veterans who did not display full symptomatology for a PTSD diagnosis (Kornfield, Klaus, McKay, Helstrom, & Oslin, 2012). Partial PTSD is associated with minor functional impairment and is just as common as full diagnostic PTSD (Kornfield et al., 2012). If left untreated, partial PTSD can become more severe and lead to further complications such as explosive anger, severe depression, acute stress disorder, medical issues, and full-blown PTSD (Dickstein, Walter, Schumm, & Chard, 2013; Frommberger et al., 2014; Jakupcak et al., 2007; Kornfield et al., 2012).

The current theoretical perspective of PTSD suggests that it is derived from the deregulated emotional fear response in relation to the traumatic event (the biological/physiological manifestation will be discussed in greater length later in this section) (LaBash & Papa, 2014). LaBash and Papa (2014) posited that fear related memories will, over time, generalize to other types of stimuli creating a constant state of hyperarousal and thus maintaining the PTSD symptoms. Furthermore, a growing body of research suggests that the emotions of shame and guilt can be easily attached to the trauma survivor, subsequently complicating the use of necessary treatments therein (LaBash & Papa, 2014). As a result of the manifested shame and guilt, trauma survivors with full or partial PTSD often have a harsh negative view of self (e.g. being powerless and/or inadequate), thus promoting the framework of self-blame (LaBash & Papa, 2014). This brief diagnostic and etiological understanding of PTSD will effectually inform the lens through which veteran survivors with full or partial PTSD are understood throughout the remainder of this study.

PTSD and Veterans.

Historical Perspective. Trauma has been a consistent theme within the historical framework of warfare. Where there is combat, there is the potential for the development of trauma related symptomatology. Within the fabric of American history, combat-related trauma has been traced back to the Revolutionary War (1775-1783) (Nidiffer & Leach, 2010). Individuals suffering from combat-related trauma were categorized with deserting and/or malingering soldiers and were often given the same punishment (Nidiffer & Leach, 2010). Punishments would range from having their heads shaved, tarred and feathered, and run the gauntlet, to flogging, to being placed in a cage, to being shackled to a twenty to thirty pound log and having to drag it along for days (Nidiffer & Leach, 2010).

The conceptualization of combat-related trauma in the Civil War (1861-1865) was similar to that of the Revolutionary War. However, military doctors began to diagnose soldiers with “exhaustion” rather than dismissing, diminishing, or punishing the behavior (Eagan Chamberlin, 2012; Nidiffer & Leach, 2010). Characterized by a complete mental shutdown, modern doctors have identified several predetermined characteristics for the development of “exhaustion” in Civil War soldiers, which has helped inform the understanding of modern PTSD (Nidiffer & Leach, 2010). The characteristics are: (a) lower IQ; (b) age at enlistment; and (c) high degree of combat exposure (Nidiffer & Leach, 2010). 620,000 lives were lost in the Civil War, with many casualties related to untreated psychiatric disorders.

In the decade after the conclusion of the Civil War, Dr. Mendez Da Costa expanded the interpretation of “exhaustion”, by providing a medical label for the disorder called the “soldiers-heart” (Eagan Chamberlin, 2012; Nidiffer & Leach, 2010). Further expanding this ideology, Dr. Arthur Meyer developed a list of similar symptoms among Civil War combat veterans.

Symptoms such as: arousal of the cardiovascular system, fatigue, dyspnea, heart palpitations, sweating, tremors, and loss of consciousness were common (Nidiffer & Leach, 2010). Nearly, 3.3 out of 1000 Civil War combat veterans struggled with the aforesaid symptoms (Eagan Chamberlin, 2012; Nidiffer & Leach, 2010).

With the development of modern warfare and the introduction of trench warfare in World War I (1914-1918), there had become an epidemic of mental breakdowns among troops (Eagan Chamberlin, 2012). Known as “shell shock” or “shell concussion”, symptoms were thought be a physiological response to the violent interaction with mortar shells. It was later discovered that soldiers who did not directly experience mortar bombings also experience similar emotional and behavioral symptoms, thus refuting the previous “concussion” theory (Nidiffer & Leach, 2010). By the end of the war, “shell shock” or “shell concussion” had affected over 80,000 individuals. Similar to the earlier symptomatic expressions of combat-trauma, individuals experiencing both emotional and behavioral problems were considered weak and thus ostracized by their peers (Eagan Chamberlin, 2012).

By the start of World War II (1939-1945) doctors changed the name from “shell shock” to “battle fatigue”, so as to better encompass the symptomatic understanding of combat related trauma (Nidiffer & Leach, 2010). Nearly 30% of active duty soldiers were unable to complete their assigned duties and were unable to complete their tours of duty (Nidiffer & Leach, 2010). Approximately 400,000 soldiers were directly affected by battle fatigue and were sent home for their psychiatric problems (Nidiffer & Leach, 2010). Furthermore, research has indicated that of those affected by battle fatigue in WWII, 56% were chronically ill or dead by the age of 65.

The Vietnam War (1955-1975) was a publically debated war that enhanced the emotional and psychological difficulties of returning soldiers (Nidiffer & Leach, 2010). Soldiers not only

faced combat related trauma but also were confronted by the social related trauma upon their return home (Eagan Chamberlin, 2012). “Post-Vietnam Syndrome” was one of the leading causes of attrition in Vietnam, thus eventually causing doctors to take notice, and as a result the term PTSD was finally coined in 1980 as a part of the third edition of the *Diagnostic and Statistical Manual for Mental Disorders* (Eagan Chamberlin, 2012).

Current Manifestation. Recent military conflicts such as OIF and OEF in Afghanistan have been two highly publicized wars (Erbes et al., 2009), consuming both public and political attention for over a decade. Since September 11th, 2001, over 2 million American men and women have served in OIF/OEF with more than 800,000 serving multiple deployments (Fissette et al., 2014). Though these conflicts are coming to an end, the ripple effects on those that have served are just now starting to be researched. Over 5,000 men and women have given their lives to these conflicts, with approximately 16,000 physically injured (Held & Owens, 2012). Of the approximately 21,000 physically affected or killed by these atrocities of war, hundreds of thousands of other military personnel bear a different type of scar. The psychological and emotional impact of these conflicts are significant with somewhere between 30 to 45% of returning personnel meeting criteria for some form of mental illness, with 12 to 22% meeting criteria for PTSD (Fissette et al., 2014; Kelley et al., 2014).

Combat Related PTSD. Warzone exposure and combat-related PTSD vary significantly from that of civilian PTSD. PTSD amongst the civilian population is categorized as an anxiety related disorder that can symptomatically develop over a period of time following an experienced and/or witnessed single life threatening event (Fragedakis & Toriello, 2014; La Bash & Papa, 2014). Though an individual might experience multiple traumatic events over a lifetime, this varies significantly from the trauma experienced by service men and women facing

combat-related events. Combat-related PTSD is developed over time and with repeated exposure to direct combat and/or threat of direct combat (Fragedakis & Toriello, 2014). Brenner, Vandeploeg, and Terrio (2009) espouse that service members who were actively engaged in OIF and OEF not only experienced traditional firefight, but were also confronted with the continuous threat of roadside bombs and improvised explosive devices (IED's). Subsequently, these chronic threats of harm resulted in both complex psychological and physiological symptoms.

Effectually, the brain and the central nervous system (CNS) are designed to protect the body and the mind from the potential of danger. The amygdala is the key emotional region of the brain responsible for threat detection, fear conditioning, and emotional salience (Sripada et al., 2012). The medial prefrontal cortex (mPFC) is designed to act as an interconnected modulator with the limbic system, thus effectively contributing to emotional regulation (Sripada et al., 2012). To maintain a successful combat operation, military service members are trained to operate out of a heightened level of physiological arousal, thus increasing the likelihood of survival (Fragedakis & Toriello, 2014). Physiologically when an individual is confronted with a dangerous situation, such as combat, the neuropathways of the brain induce the release of excitatory stress neurotransmitters such as endorphins and norepinephrine (Fragedakis & Toriello, 2014). With the release of endorphins and norepinephrine the sympathetic nervous system is activated and engages the life-saving fight or flight response (Fragedakis & Toriello, 2014). When an individual is exposed to multiple life threatening or traumatic events over time, the body will continue to produce endorphins and norepinephrine so as to accentuate the fight or flight response (Fragedakis & Toriello, 2014). This allows the service member to maintain the necessitated level of heightened awareness and subsequent preparedness for combat. After time these hormone channels are left on and the structure of the service member's brain (primarily the

hippocampus, which is responsible for memory, and the amygdala, which is responsible for emotions) is changed (Fragedakis & Toriello, 2014).

Recent functional magnetic resonance imaging (fMRI) studies of individuals with PTSD have indicated a hyperactivation of the amygdala and the insula regions of the brain and a hypoactivation of the ventromedial prefrontal and rostral anterior cingulate cortices (Sripada et al., 2012). Similar to the findings of Fragedakis and Toriello (2014), further fMRI studies show that individuals with PTSD have disrupted patterns in the insula, which controls and is responsible for the recognition and processing of emotions, emotional recall, and anticipation of adverse stimuli (Sripada et al., 2012). Further complicating the body's reaction to trauma is the adverse impact on the hippocampus. The hippocampus (responsible for memory) is adjacent to the amygdala and is located in the medial temporal lobe region (Sripada et al., 2012). The hippocampus controls and stores an individual's declarative and contextual memory along with modulating the fear response (Sripada et al., 2012). Though fMRI findings provide somewhat conflicted results (e.g. hyperactivating vs. hypoactivating), several meta-analyses have shown reduced hippocampus activity in individuals suffering with PTSD (Sripada et al., 2012). Since it is theorized that the hippocampus might control the integration of context into emotional memories (Sripada et al. 2012), veteran survivors with PTSD are unable to remove themselves from the emotional reliving of the combat-related trauma and without access to effective treatment will struggle with the continued adverse symptomology.

Recent statistics indicate that post-deployment up to 37% of returning service members will have a diagnosis of some mental disturbance with PTSD being the most prevalent at 22% (Fissette et al., 2014). Hoge, Castro, Messer, McGurk, Cotting, and Koffman, (2004) conducted a study of marines returning from either an OIF or an OEF deployment (*n* 3,671). The results

from an anonymous survey, the authors discovered significantly high rates of trauma exposure with the most common types being: (a) artillery, rocket, or mortar fire (87%); (b) being shot at (80%); (c) seeing dead bodies and/or handling remains (65%); (d) being attacked or ambushed (74%); and (e) knowing someone who was seriously injured and/or killed (63%) (Hoge et al., 2004). Though this study was focused on post-deployed marines, more than 75% of all U.S. military forces stationed overseas have reported exposure to similar traumatic, life threatening, and deleterious events (Albright, & Thayer, 2010). This trauma exposure and subsequent combat-related PTSD has been consistently linked to several negative outcomes, including family and marriage issues, job instability, legal difficulties, physical health problems, anxiety, depression, and substance use (Gates et al., 2012).

Stigma. Screenings conducted with returning veterans indicate a symptomatic developmental struggle with mental health issues increasing in severity post-deployment. Gibbs et al. (2011) suggest that at 3 to 6 months post-deployment 27% of active duty personnel report clinically significant impairment including PTSD. Studies differ on the severity of post-deployment combat-related PTSD, with ranges from as low as 4% to as high as 37% (Borah et al., 2013; Erbes et al., 2009; Fissette et al., 2014; Gates et al., 2012; Goodson, Lefkowitz, Helstrom, & Gawrysiak, 2013; Kelley et al., 2014; Possemato, McKenzie, McDevitt-Murphy, Williams, & Ouimette, 2014; Tuerk, Yoder, Grubaugh, Myrick, Hamner, & Acierno, 2011). Though the rates of PTSD are varied, Gibbs et al. (2011) asserts that service members unanimously described mental health problems as both normal and significantly problematic. Though there is a known need, there is however a disparity in the involvement with appropriate therapeutic treatments with only 38-45% of veterans actively seeking treatment (Gibbs et al.,

2011). Unfortunately, there is a stigma that has developed with in the military culture that inhibits many service members and veterans from seeking out treatment.

The stigma of mental health problems can be traced back to the Revolutionary War wherein soldiers were given the same punishment as deserters and maligners (Nidiffer & Leach, 2010). Whether intentional or not, this underlying stigma has permeated the service member culture with many individuals (both active duty and veteran) foregoing therapy to avoid the perceived adverse stereotyping. Gibbs et al. (2011) conducted a study looking at the dynamics of stigma attached to alcohol and mental health treatments among active duty soldiers and discovered a significant ambivalence in the responses. Though many of the responses indicated that mental health issues were a part of the job and an occupational hazard, the responders also indicated that the acquired mental health issues were not compatible with on-going military service (Gibbs et al., 2011). Nevertheless, mental health services were not readily sought out or regularly utilized. Held and Owens (2012) posited that the reluctance to utilize mental health services stems from the machismo culture of the military where any form of need, whether mental, physical or emotional is considered as weak. This perceived weakness creates an attitude of disrespect towards the one in need of help while false strength, or ignoring any issues, is glorified. Many service members have indicated (through an anonymous survey) that receiving treatment would cause peers to see them as weak (65%) (Gibbs et al., 2011; Held & Owens, 2012), that they would be treated differently by their commanding officers (63%) (Gibbs et al., 2011), that peers would lose trust in them (59%), that they would be blamed for their problems (51%) (Gibbs et al., 2011), and that their careers would be in jeopardy (50%) (Gibbs et al., 2011; Held & Owens, 2012; Kelley et al., 2014).

Further complicating the stigma within the military culture, is that of the societal stigma wherein service members and veterans struggling with a mental disorder are often viewed as not being able to carry their own weight (Held & Owens, 2012). Furthermore, the negative social reaction of returning service members and veterans are significantly damaging to the attempted adjustment/reintegration therein (Schumm, Fredman, Monson, & Chard, 2013a). Often it appears that society underestimates and/or overlooks the severity of the combat-related trauma and expects veteran survivors with PTSD to re-integrate into society without complications (Fragedakis et al., 2014; Schumm et al., 2013a). With this misunderstanding of combat related-mental illness, veteran survivors also face the potential for discrimination in housing, work, health care, and even in the legal system (Mittal, Drummond, Blevins, Curran, Corrigan, & Sullivan, 2013).

Current use of Evidenced Based Therapeutic Interventions. In an attempt to combat the aforesaid within military culture stigma as well as the perceived societal stigma, the Department of Defense (DoD) and the Veterans Affairs (VA) have attempted to develop and/or approve several evidenced based practices. Evidenced based practices are intentionally utilized for their proven reliability, validity, and generalizability. Though most of the utilized evidenced based practices have been previously tested on civilian populations, both the DoD and the VA have approved CPT, PE, and EMDR as viable therapies for treating combat-related trauma (Brenner et al., 2009; Monson et al., 2006; Peterson et al., 2011; Possemato et al., 2011).

Cognitive Processing Therapy. Originally develop for women survivors of sexual abuse (Monson et al., 2006), CPT shares many of the key components of CBT (e.g. challenging automatic negative thoughts) (Sharpless & Barber, 2011). CPT is typically offered in 12-session format and intentionally focuses on engaging survivors in the narrative component of his or her

trauma exposure (Sharpless & Barber, 2011). Specifically, CPT consists of three structured components: (a) psychoeducation; (b) cognitive restructuring; and (c) narrative exposure (Peterson et al., 2011; Resick, Nishith, Weaver, Astin, & Feuer, 2002). CPT is fundamentally rooted in the understanding of information processing wherein it is postulated that the networks of fear (e.g. as a result of the trauma) consist of stimuli, responses, and the interpretation (e.g. meaning making) of the stimuli/responses (Peterson et al., 2011). In addition, CPT is designed to address the specific cognition(s) related to committing, witnessing, and experiencing acts of violence, which are often a concurrent struggle with combat related trauma survivors (Monson et al., 2006).

Prolonged Exposure. Since 2007, PE has been an approved therapeutic modality of the treatment of PTSD with veteran survivors (Borah et al., 2013). Effectually, PE consists of 10-12 90-minute sessions and typically consists of four key components (Peterson et al., 2011). First, therapy is focused on psychoeducation, where the client is educated about the etiology of PTSD, the symptomology of PTSD, and the course of treatment. Second, the client is properly trained in the art of mindful breathing, thus preparing the client for the later exposure portion. Third, the client is guided through a series of imaginal exposure techniques in preparation for the fourth component of in vivo exposure (Peterson et al., 2011). Both the imaginal and in vivo exposure portions of therapy are intended to encourage acclimatization into the relived traumatic memories (Peterson et al., 2011). Essentially, the process of PE is meant to reduce the active re-experiencing symptoms of the PTSD by a reorientation of the memory structures (e.g. hippocampus) underlying emotional hyperactivity (Sharpless & Barber, 2011).

Current research on the effects of PE with combat related PTSD is minimal, however, there are several studies that have explored the potential efficacy therein. Goodsen et al. (2013)

conducted a naturalistic effectiveness study of 115 veterans. Of the original population (n=115), 31 (27%) dropped out, while 84 (73%) completed at least 8 sessions (Goodsen et al., 2013). Results found a significant decrease in overall PTSD symptoms with quality of live increasing (Goodsen et al., 2013). Another study conducted by Tuerk et al. (2011) reviewed clinical outcome data on 65 OIF and OEF veterans treated with PE. Results indicated that only 43 (66%) of the veterans met criteria for completion (Tuerk et al., 2011). Effect sizes were large (ITT sample d=1.19; treatment completer, d=2.07), which are similar to civilian randomized control studies (Tuerk et al., 2011). The authors posited that PE, if conducted appropriately, could be an effective treatment modality for veteran survivors with PTSD (Tuerk et al., 2011).

Eye Movement Desensitization and Reprocessing. Another form of exposure therapy is eye-movement desensitization reprocessing (EMDR). EMDR is a manualized treatment integrating specific components of CBT, mindfulness (including body based approaches), and aspects of person-centered therapies and techniques (Sharpless & Barber, 2011). The fundamental component of EMDR is the intentional refocusing of the traumatic memory while concurrently focusing on an alternative stimuli (typically, following the therapists fingers as they are being waved in a right to left motion) (Albright & Thyer, 2010). Functionally, EMDR postulates that it can access, process, and desensitize traumatic memories by removing the emotional distress while reformatting subsequent cognitions (Albright & Thyer, 2010). Though there have been extensive studies conducted on diverse populations, little is known about EMDR's effects on combat-related trauma and the established nuances therein (Albright & Thyer, 2010).

Barriers to Current Treatment. Though the DoD and the VA have vetted efficacious, evidenced based treatments, significant barriers still exist. First, mental health clinics are not

always a good option inasmuch as there is a fear that peers and/or society will pass judgment (Cigrang et al., 2011). Second, many providers do not use manualized therapies due to the lack of proper training, lack of qualified supervisors, lack of funding, and lack of qualified staff (Borah et al., 2013). Third, little is known about the history, outcomes and treatment patterns with veteran survivors with PTSD. Therefore, the appropriate long-term diagnostic and treatment protocols may not be properly in place to effectively support this population (Foa et al., 2005, Rosen et al., 2011).

The use of Animals in Therapy

Animal Assisted Therapy.

History. Civilizations have valued animals for centuries with many ancient people groups finding value in in the interrelatedness between animals and humans (Walsh, 2009). Lewinsohn (1954) posited that it was not mistake that ancient man's earliest artistic expressions were Paleolithic paintings of bison and horses. Levinson (1969/1997) stated, "pets were popular in the ancient world; just like today, the wealthy owners of pets spent untold sums of money on their favorite pets" (p. 7). He goes on to describe the ancient dogs of the emperors in China, the golden shod mule owned by Nero's wife, and the Nubian cats of ancient Egypt (Levinson, 1969/1997). Not only have pets been associated with wealth and prestige, they have also been partners in the health, healing, and survival of humankind (Walsh, 2009). Walsh (2009), indicated that many spiritual traditions have cherished the relationship between humans and animals as a symbolic interrelated connectedness bridging the natural and spiritual worlds.

The intentional therapeutic extrapolation and/or utilization of pet assisted/AAT can be traced back as early as 1792 where animal related activities were included as a part of the weekly schedule in a psychiatric facility near York, England (Chu, Liu, Sun, & Lin, 2009; Levinson,

1969/1997). In 1869, Florence Nightengale discovered the benefits of animal companionship and mentioned its positive effects with wounded soldiers in her nursing diary (Chu et al., 2009). Within the United States, the first mention of pet-assisted/animal-assisted activities was in 1919 at St. Elizabeth's Hospital in Washington DC as an adjunct therapy with psychiatric patients (Chu et al., 2009). In 1942, Pawling Army/Air Force Base Convalescent Hospital in Pawling, New York, utilized companion animals as an integral part of the recovery process with individuals struggling with fatigue and other injuries (Behling, Haefner, & Stowe, 2011).

Though these early accounts of the intentional integration of animals in both physical and psychological institutions demonstrate positive outcomes, they are anecdotal at best. It was not until the early 1960 with the research of Boris Levinson, that pet therapy began to gain notoriety. Boris Mayer Levinson was born in Kalvarijah, Lithuanian in 1907 (Levinson, 1969/1997). Levinson immigrated to the United States as a teenager and settled with his family in East Brooklyn, (which at the time was still located in the countryside) (Levinson, 1969/1997). Growing up, Levinson was acutely aware that humankind was becoming less and less connected with their natural environments, thus losing touch with how they were created (Levinson, 1969/1997). Levinson received his bachelors and masters of science from the City College of New York in 1937/1938, and then received his doctorate of clinical psychology from New York University in 1947 (Levinson, 1969/1997). Professionally, Levinson was a psychoanalytically trained child psychologist, a professor at the Ferkauf Graduate School of Humanities and Sciences at Yeshiva University in New York, a diplomat in clinical psychology, and an active member of the American Board of Examiners in Professional Psychology (Levinson, 1969/1997).

Pet-therapy or later know as pet-oriented child psychotherapy was actually an accidental discovery (Levinson, 1969/1997). Levinson primarily worked with severely autistic children at the Blueberry Treatment Center for Children in New York and in 1962 found that when his dog Jingles was present in session, the child would make significant strides of improvement (Aoki et al., 2012; Levinson, 1969/1997). From this initial accidental discovery, Levinson developed his seminal work title "Pet-Oriented Child Psychotherapy" (Risley-Curtiss, 2010). According to Levinson (1969/1997), companion animals had the ability to strengthen the therapeutic rapport between the therapist and the client, thus expediting and subsequently enhancing the therapeutic process (Risley-Curtiss, 2010; Zilcha-Mano, Mikulineer, & Shaver, 2011). For nearly a decade, Levinson (1969/1997) continued to integrate the use of animals into his psychotherapy sessions, he studied the effects, noted themes, developed techniques, and published conference papers and articles. Though pet-assisted child psychotherapy was gaining popularity, it was solely the work of Levinson until the early 1970's when Corson and Corson from Ohio State University began working with Levinson's techniques (Behling, Haefner, & Stowe, 2011; Levinson, 1969/1997). Conducting on of the earliest studies on pet-therapy, Corson and Corson discovered significantly positive results in approximately 28 patients who had previously failed to respond to electro-shock therapy and psychotropic medications (Levinson, 1969/1997). Since the early 1970's, numerous research studies have demonstrated the adjunct benefits of pet-oriented psychotherapy. Prior to his untimely death in 1984, Levinson postulated that for pet-oriented psychotherapy to gain scientific footing, research needed to focus on four areas:

1. The role of animals in various human cultures and ethnic groups over the centuries.
2. The effect on human personality development of association with animals.
3. Human-animal communication.

4. The formal use of animals in formal psychotherapy.

(Levinson, 1969/1997, p. xiv)

Framework Overview. Since Levinson's (1969/1997) initial formulation of pet-oriented child psychotherapy in the 1960's, a growing body of literature has emerged demonstrating the benefits of animals within the therapeutic alliance. Despite this growing body of literature, pet-oriented/animal-assisted therapy is typically categorized as a beneficial complimentary/adjunct therapy (Kruger & Serpell, 2010). Though the benefits of AAT are countless, the field as a whole lacks in research that demonstrates both empirical support and statistical validity (Stewart, Chang, & Rice, 2013). In an attempt to provide consistency and structure to the profession, the Delta Society (2015) (an accrediting body for therapy animals) defines AAT as:

> a goal-directed intervention in which an animal that meets specific criteria is an integral part of the treatment process. AAT is directed and/or delivered by a health/human service professional with specialized expertise, and within the scope of his or her profession (para. 1)

Utilizing the definition extrapolated by the Delta Society (2015) it is important to understand that AAT is the intentional integration of the animal into the therapeutic milieu, rather than just a random interaction with a pet (Behling, Haefner, & Stowe, 2011; Chandler et al., 2010). Furthermore, the utilization of AAT requires the counselor to develop a set of competencies, and establish a highly developed working relationship with a therapy animal (Stewart, Chang, & Rice, 2013).

Practically, AAT is the intentional utilization of an animal in the structured therapeutic setting (Behling et al., 2010). Within the framework of AAT, the animal becomes a partner or a co-therapist in the treatment, rather than just a tool to enhance therapy (Chandler et al., 2010).

Through this unique partnership, the animal is able to engage the client in an empathic, compassionate, non-judgmental, and stimulating way, thus aiding in the facilitation of goal-directed change (Chandler et al., 2010; Marcus et al., 2013).

Though the field of AAT continues to struggle with continuity across the therapeutic spectrum (e.g. applying a specific theoretical framework across the field of counseling) (Kruger & Serpell, 2010), consistent themes continue to emerge within the research. Wesley, Minatrea, & Watson (2009) suggested that AAT can strengthen the overall therapeutic relationship, thus allowing for quicker therapeutic trust and the subsequent outcomes therein. Marcus et al., (2013) indicated that not only is the therapeutic alliance strengthened, but, the overall healing environment is optimized. Confirming this assertion, research has indicated a reduction in cardiovascular stress, an improvement in neurophysiological stress factors (Gonzalez-Ramirez, Ortiz-Jimenez, & Landero-Hernandez, 2013; Marcus et al., 2013), an enhanced alertness (Behling, Haefner, & Stowe, 2011), increased client verbal interaction (Wesley, Minatrea, & Watson, 2009), and significantly decreased systolic and diastolic blood pressure (Aoki et al., 2012). In conjunction with the physiological benefits of AAT, there are also numerous psychological benefits as well. AAT has been shown to reduce anxiety (Wesley, Minatrea, & Watson, 2009), increased positive social behaviors, enhanced self-esteem, decreased depression (Chandler et al., 2010), enhanced a sense of security, promoted unconditional love and acceptance (Risley-Curtiss, 2010), and improved overall social functioning (Chu et al., 2009).

Empirical Support. Though empirical support remains limited, there are several studies that demonstrate the potential efficacy of AAT. In their original study of nursing home patients, Corson and Corson (1978) indicated that patients reported overall improvements in the desire to live, alertness, happiness, enjoyment, and interest in others. Similarly, Behling, Haefner, and

Stowe (2011) reported through a longitudinal study that animal assisted programs in long-term care facilities were thought to be 85% beneficial in 1990 and 88.1% beneficial in 2010. Marcus et al. (2013) conducted an "open-label study" (p. 44) in an outpatient pain management clinic. A total population of one hundred and thirty-three (n=133) participated in the study with 84 meeting with a therapy dog and 49 filling out waiting room surveys. Pre and posttest interventions demonstrated significant symptom change in those that met with the dog as opposed to those who simply filled out the waiting room survey (Marcus et al., 2013). Pain levels, stress and aggravation levels, and sadness levels decreased, while levels of calmness, pleasantness, and cheerfulness significantly increased (Marcus et al., 2013).

Aoki et al. (2012) conducted a pilot study that measured the cerebral activity in the prefrontal cortex in mood disordered individuals during AAT with a dog, compared to the use of verbal fluency tasks (VFT). The authors utilized near infrared spectroscopy (NIRS) which measures cranial nerve activity in real-time (Aoki et al., 2012). NIRS also has the capability to measure the changes in concentration in both oxygenated and deoxygenated hemoglobin in the gas exchange circulation and blood tissue volume (Aoki et al., 2012). Simply, the measure of oxygenated and deoxygenated hemoglobin demonstrates the amount of brain function or the lack therein when given a task (e.g. AAT or VFT) (Aoki et al., 2012). Through this pilot study the authors discovered that AAT influenced the "living body biologically and physiologically because, the NIRS signal reflects oxygen metabolism in the cerebral blood, a change in blood volume, etc." (p. 210). Therefore, the participants were able to engage in a bidirectional exchange, which allowed for a combination of senses to be aroused (e.g. sight, touch, smell, sound, etc.), thus enhancing the treatment results (Aoki et al., 2012).

Zilcha-Mano, Mikulineer, and Shaver (2011) explored the use of animals in therapy from an attachment perspective. The basic assumption of attachment theory is that individuals will form either a secure or insecure attachment based off of the relational figures present in their early experiences (Zilcha-Mano, Mikulineer, & Shaver, 2011). These social interactions are then internalized as both conscious and unconscious representations of self (Colle & Del Guidice, 2010). These internal models are responsible for regulating emotions and behaviors, and if a supportive, secure attachment is present, emotions and behaviors should be appropriately regulated (Zilcha-Mano, Mikulineer, & Shaver, 2011). Without a secure, stable attachment figure, emotions and behaviors will have a difficult time regulating (Zilcha-Mano, Mikulineer, & Shaver, 2011). The authors argue that attachment theory can provide a framework for understanding the human-animal bond inasmuch as animals meet the four prerequisites for a secure attachment bond: “proximity seeking, safe haven, secure base, and separation distress” (Zilcha-Man, Mikulineer, & Shaver, 2011, p. 543). Therefore, animals can be viewed as secure attachment figures, thus aiding in the reparation of previous harm.

In another study, Prothman, Albrech, Dietrich, Hornfeck, Stieber, and Etrich (2005) reported that youth receiving standardized inpatient psychiatric treatment who participated in AAT as an adjunct, were more attentive, engaged, and forthcoming when the therapy dog was present. This led the authors to conclude that the therapy dog established a therapeutic environment of warmth, acceptance, security, and empathy (Prothman et al., 2005). Prothman’s (2005) findings coincide with previous research, showing that AAT provides the client with a surrogate for therapeutic touch (Wesley, Minatrea, & Watson, 2009). The client is also able to develop a sense of security and unconditional love (Risley-Curtiss, 2010), the enhanced moderation of stress responses (Geist, 2011), and the animal serves as a transitional object

whereby, the client can convey thoughts, feelings, and fears to the animal, thus servicing as a bridge to the counselor (Stewart, Chang, & Rice, 2013).

Equine Therapies.

History. Under the umbrella of AAT is the framework of equine therapies. Though a relatively new field, equines have been referenced throughout history as possessing healing qualities for their human counterparts (Bachi, 2012). Burgon (2013) states that “horses have played a fundamental role in shaping our modern world since they were first ridden” (p. 52) millennia ago. Historical examples of the therapeutic benefits can be traced back to 5 B.C. (Selby & Smith-Osborne, 2013). The Pech-Merle cave paintings, of France, depict early importance of the horse (Burgon, 2013), Orebasius, Galen, and other Greco-Roman authors discussed the therapeutic properties of horses (Bachi, 2012), and Hippocrates provided the first comprehensive description of the therapeutic benefits of horseback riding, describing it as a “universal exercise with a healing rhythm” (Granados & Agis, 2011, p. 191).

The innate value of horseback riding for physical rehabilitation was not fully recognized until 1875 when physiotherapist Chassaignc discovered that the physically challenged could strengthen muscles, enhance range of motion, increase balance, and improve overall well-being by riding a horse (Granados & Agis, 2011). Similarly, horses were used to enhance the quality of life and well-being of injured British WWI veterans in the late 1920’s and 1930s (Selby & Smith-Osborne, 2013). It was not until the 1950s that the term therapeutic riding was established through the work of Hartel (Bachi, 2012). Since the 1950s, the utilization of equine therapies has grown to include HPOT, TR, EAL, equine assisted psychotherapy (EAP), and EFP (Lentini & Knox, 2008; Wehofer, Goodson, & Shurtleff, 2013).

Even though there is not a universal, empirically based psychotherapeutic structure for equine therapy, there are two main governing agencies that accredit and certify the center and the horse handler. PATH International was formed in 1969 as the North American Riding for the Handicapped Association (NARHA) as an attempt to promote EAA/T (PATH International, 2015). Currently, PATH International has certified over 4500 instructors and equine specialists and has accredited more than 850 centers around the world (PATH International, 2015). Each year, approximately 58,300 children and adults with cognitive, physical, and emotional disabilities are impacted through the use of HPOT, therapeutic riding (TR), and/or EFP (PATH International, 2015).

Parallel to PATH International, the Equine Assisted Growth and Learning Association (EAGALA) was founded in 1999 with the desire that “every person worldwide will have access to these therapy services” (EAGALA, 2010, para. 1). EAGALA is considered to be the “leading international nonprofit association for professionals using equine therapy (horse therapy) to address mental health and human development needs” (EAGALA, 2010, para. 1). Like PATH International, EAGALA certifies centers and trains individuals to provide both equine assisted psychotherapy and EAL.

Equine Assisted Activities and Therapy. EAA/T is a broad term that typically encompasses HPOT, TR, EAL, equine assisted psychotherapy (EAP), and EFP. Due to the lack of standardized operational definitions, terms like equine assisted experiential therapy (EAET), equine facilitated therapy (EFT), EAT, and psychotherapeutic riding were also found in the literature. For the purpose and scope of this literature review, focus will only be placed on HPOT, TR, EAL, and EFP/EAP. Prior to exploring the specific therapeutic extrapolations of equine therapy, it is important to understand fully the nature and the power of the horse.

Nature of the Horse. Understanding the nature of the horse provides a general foundation into the innate benefits of EAA/T. In the natural world, horses are prey animals (Johansen, Arfwedson Wang, Binder, & Malt, 2014; Porter-Wenzlaff, 2007), and for survival they are designed to be keenly attuned and sensitive to their environment (Brandt, 2013; Johansen et al., 2014). Biologically, horses have several unique features. First, their eyes are strategically placed on the sides of the head, and with horizontal pupils, they have an approximate 340-degree visual field. This scope of vision allows them to effectively scan the horizon for potential danger (Porter-Wenzlaff, 2007). Second, horses have ears that are able to operate independent of each other and can be positioned to catch specific sounds within a 360-degree range (Porter-Wenzlaff, 2007). Third, their hooves are connected to the ground and are highly sensitive to vibrations. Fourth, they have a keen sense of smell (Porter-Wenzlaff, 2007), and often communicate to each other through breath. Finally, the hemispheres of the horse's brain are divided into two unconnected parts. This allows each side of the brain to be fully in tune to the surrounding environment (Porter-Wenzlaff, 2007). As a result of the horse's biology, they are highly sensitive, sentient beings and have the ability to give, received, and feel emotion. Pragmatically, horses are constantly assessing the intentions, emotions, and body language of the herd, other animals, predators, and their human counterparts (Johansen et al., 2014). As herd animals, the success of their survival depends on the reciprocal communicative interaction between the members of the herd and their immediate environment (Brandt, 2013).

These sensitivities transfer over to the human-horse interaction, allowing the horse to become a live bio-feedback mirror (Johansen et al., 2014). Since horses rely heavily on non-verbal communication, the congruence of the human is tantamount to the success of the relationship (Brandt, 2013; Johansen et al., 2014; Porter-Wenzlaff, 2007). When the human

participant is incongruent in any way (e.g. thoughts, feelings, and behaviors), the horse becomes agitated and confused, and will mirror back what is being felt (Brandt, 2014; Porter-Wenzlaff, 2007). To ensure their safety, the horse demands congruence in the here-and-now. This opportunity provides the human participant with the tangible ability to reflect on his or her emotional experience in the present, correct the inconsistencies, and actively apply pro-social/emotional skills in the moment (Brandt, 2013). This therapeutic experience will be discussed at length in the following equine facilitated/assisted psychotherapy section.

*Hippotherapy***.** HPOT is a highly popular therapeutic treatment within the framework of EAA/T. "Hippo" (the Latin word for horse) therapy, is a commonly used therapy for individuals struggling with physical ailments (Snider et al., 2007). HPOT is typically provided in collaboration with a physical therapist or a rehabilitation specialist and focuses on the positive effects of the horse's movement on the participant (Drnach, O'Brein, & Kreger, 2010). Classic HPOT began in Germany and spread throughout Europe in the 1960's (Granados & Agis, 2011). This original form of HPOT consisted of one disabled rider, one certified rehabilitation specialist, and a horse (Granados & Agis, 2011). The rehabilitation specialists relied on the three-dimensional movement of the horse to stimulate proper movement and activate the passive body of the rider (Granados & Agis, 2011; Drnach et al., 2010; Snider et al., 2007). Effectually, the movement of the horse simulates the proper movement of the pelvis during walking thus enhancing core strength and improving balance (Drnach et al., 2010; Snider et al., 2007). Modern HPOT builds on the foundation of classic HPOT and expands the original concepts by focusing on the psychologic effects as well (e.g. psychological, cognitive, emotional, and social-behavioral) (Granados & Agis, 2011). The positive effects of HPOT have been linked to improved balance, increased muscle symmetry and strength, enhanced ranged of motion, reduced

stress and anxiety, and the development of social skills (Granados & Agis, 2011; Snider et al., 2007). Confirming these findings, Tseng et al. (2013) indicated that HPOT reduced the asymmetrical hip abductor activity and increased motor capacity.

Therapeutic Riding. Similar to HPOT, therapeutic riding enhances the client experience by adding an additional component. Instead of the client being a passive participant, they are given the opportunity to learn to ride (Snider et al., 2007). The added component of riding provides an avenue whereby the client learns to connect, control, and lead the horse thus allowing for the development of both an enhanced physical control and a psychological control (Bass et al., 2009; Cuypers et al., 2011; Snider et al., 2007). Numerous studies have explored the effects of therapeutic riding on the physically disabled and the autistic client. Kern et al. (2011) designed a study to examine the effects of therapeutic riding on children with autism spectrum disorder. Using the Child Autism Rating Scale (CARS), 24 children participated in the treatment for over a period of six months. Results of the treatment yielded a significant decrease in the Child Autism Rating Scale (Kern et al., 2011). Another study by Memishevikj and Hodzhikj (2010) examined the effects of therapeutic riding on the psychosocial functioning of four children diagnosed with autism spectrum disorder. The authors used the Autism Treatment Evaluation Checklist to evaluate the change in symptomology. The study revealed mixed results with two participants showed significant improvement in three of the four areas, while two participants did not show any improvement at all (Memishevikj & Hodzhikj, 2010). Cuypers, Derider, and Strandheim (2011) studied the therapeutic effects of therapeutic riding on children diagnosed with attention deficit hyperactivity disorder (ADHD) and found that the treatment effect increased quality in behavior and motor performance in the posttreatment evaluation.

Equine Facilitated Psychotherapy. EFP is a specific and unique extrapolation of EAA/T (Bachi, 2012). According to the Professional Association for Therapeutic Horsemanship International (PATH International), EFP is defined as:

> an interactive process in which a licensed mental health professional, working with or as an appropriately credentialed equine professional, partners with suitable equines to address psychotherapy goals set forth by the mental health professional and the client (PATH International, 2012).

This vague definition does not portray the therapeutic progression of EFP rather it provides a loose understanding of how EFP should be structured. Conceptually, EFP consists of a reciprocal and mutually beneficial relationship between the client, the therapist, and the horse (Lentini & Knox, 2008). The client's thoughts, feelings, and behaviors (either positive or negative) and the horses' response are interpreted by the therapist in the here-and-now of the session (Lentini & Knox, 2008; Selby & Smith-Osborne, 2013). As the client changes his or her thoughts, feelings and behaviors, and becomes more congruent with self, the horse then reflects back those changes by becoming more present and engaged with the client (Lentini & Knox, 2008).

Typically, EFP models utilize unmounted (e.g. non-riding) activities/exercises to engage the client (Selby & Smith-Osborne, 2013). The engagement in an experiential activity provides a platform for the client to engage in confronting wounds, maladaptive thinking, unfinished business, psychological distress, change disruptive patterns, etc. (Klontz, Bivents, Leinart, & Klontz, 2007). Trotter et al. (2008) expanded on this concept and indicated that EFP has the ability to uniquely engage a client in ways that traditional therapies cannot. The sentient nature of the horse (e.g. the ability to give, receive, and feel emotion) provides a platform whereby the client is presented, and sometimes confronted with his or her thoughts, feelings, and behaviors in

the here-and-now of the session (Frewin & Gardiner, 2005). While the client wrestles with understanding his or her thoughts, feelings, and behaviors, the horse remains a steadfast, non-judgmental, secure base, thus creating safety for the client to process (Frewin & Gardiner, 2005).

Summary and Conclusion

PTSD is distinguished by a set of symptomatological markers as espoused by the *Diagnostic and Statistical Manual of Psychological Disorders, Fifth Edition (DSM-5)*. These symptoms have the tendency to manifest in individuals who have experience a single traumatic event. If left untreated these manifestations of trauma can have adverse effects on the individual's mental, emotional, physical, and spiritual wellbeing. Combat related PTSD has many of the same makers of traditional PTSD, however it is further categorized by direct or potential engagement in warzone combat and/or multiple (compounded) exposures to traumatic events. What differentiates combat PTSD from civilian PTSD is the multiple, consistent exposure to traumatic events over a period of time.

PTSD has been a consequence of war for millennia, however, PTSD has not been given adequate attention until the official introduction to the DSM in the early 1980's. Since then, research has focused on the specific therapeutic remediation therein. Therapies such as prolonged exposure, CPT, and EMDR have been proven to provide relief for veteran survivors with PTSD. Though these therapies have been effective in the suppression of symptomatology, approximately 40% of veterans report significant distress ten years after the initial diagnosis (Lefkowitz et al., 2005; Sharpless & Barber, 2011). Recently, alternative experiential therapies have grown in popularity, yet there is minimal research to support their efficacy. Through the lens of client-centered theory, this study explored the lived experiences of veteran survivors with partial or full PTSD who were actively participating in an EFP program. Semi-structured

interviews, observations, and photo interviews were conducted, evaluated, and triangulated in an attempt to understand the lived-experiences of these veteran survivors.

Chapter 3: Research Methods

Introduction

The purpose of this qualitative collective exploratory case study was to discover the effects of EFP among veteran survivors with partial or full PTSD. I used a collective exploratory case study approach to document the experiences of the veteran participants involved in an EFP program. Veteran survivors with partial or full PTSD can often struggle to find quality, comprehensive treatment that meet the specific needs of combat related PTSD. The conclusions of this study shed light on the possible use of EFP as an alternative and/or adjunct to traditional therapy. The results of this study may be used to inform professional counselors and others in the helping profession about the therapeutic experiences of veteran survivors with partial or full PTSD.

In Chapter 3, I describe the research design and rationale, and I provide a comprehensive foundation for the subsequent research. I then discuss the role of the researcher and the specificities therein, along with an extrapolation of the specific methodological approach. I then address issues of trustworthiness, such as credibility, transferability, dependability, and confirmability in relation to the quality of a qualitative research inquiry. Overall, this chapter is a methodological guide to the study, using current qualitative methods and procedures.

Research Design and Rationale

The decision to use a collective exploratory case study stemmed from the lack of research on alternative therapies for veteran survivors with partial or full PTSD and a lack of research specifically on EFP and this population. Furthermore, owing to the nature of the chosen population, there was a care and sensitivity that must be considered, thus making an exploratory case study a suitable option. The case study methodological approach has gained significant

respect within academia as a viable option that contributes to a deeper knowledge of individuals, groups, organizations, social, and political phenomena (Yin, 2014). The case study design has several common misconceptions that can distort the true nature of the methodological approach.

First, it is often thought that quantitative theoretical knowledge is more beneficial than case study and/or qualitative phenomenological knowledge (Yin, 2014). Second, it is believed that case study research cannot be generalized to the broader population (Yin, 2014). Third, there continues to be a stigma that case study research is only beneficial for the exploratory phase, but not the descriptive stage of research (Stake, 2006; Yin, 2014). Though generalizability may not be an immediate result of a case study, through time and with the replication of studies, generalizability is a possibility. Stake (2006) indicated that a case study is an integrated system of real experiences operating in real time. The research must generate a true and accurate picture of the case and then develop an accurate portrayal for others (Stake, 2006). Providing a framework for developing an accurate picture of the studied case, Yin (2014) described three conditions for the use of case study design. First, the research must develop accurate questions (e.g., how/why questions, contextual questions). Second, the extent of researcher control must be clearly understood (e.g., over events, behaviors, and outcomes). Third, there must be a degree of focus on the present/contemporary events versus purely historical events (Yin, 2014).

The purpose of this study was to understand the lived experiences of veteran survivors with partial or full PTSD who participated in an EFP program. As the researcher, I had no control over the therapeutic process, environment of the therapeutic experience, specific standards of the ranch, or how the participants interacted therein. Furthermore, this is a contemporary issue inasmuch as there was a lack of specific research for alternative therapeutic

modalities for this new generation of veteran survivors with partial or full PTSD, thus meeting the criteria for a case study.

Yin (2014) explicitly stated that there are five components of a case study design that are important to consider: (a) constructing effective questions; (b) communicating propositions, if any; (c) identifying units of analysis; (d) effectively linking the data to the propositions and questions, and (e) establishing a clear criteria for interpreting the findings. In this study, I used research questions that explored the lived experiences of veteran survivors with partial or full PTSD who participated in an EFP program, whether or not there were benefits from the therapy, and the specific therapeutic effects therein. The propositions in this study were originally alluded to in the theoretical foundation in which I discussed the importance of client congruence and here-and-now processing. These two components are a key influence as to the success of the client-centered approach. Therefore it appears that the potential success of the therapeutic exchange between the horse, the client, and the counselor will be linked to the level of client congruence, and the ability to remain present within the here-and-now framework of the session. The units of analysis include interview data, participant observation, and a photo interview project completed by all participants. The entirety of the data will be collected over multiple contacts with the participants at the specific ranch where the EFP took place. The linking and analysis of the collected data to the research questions and propositions will be completed in Chapters 4 and 5. A dissemination of the specific analyses will be discussed later in this chapter.

Research Questions

Fundamental to the success of a qualitative collective exploratory case study inquiry is the specifically formulated questions therein. Creswell (2009) indicates that within a qualitative

inquiry the research question can have two specific forms, the central question(s) and the associated sub-questions.

Central Question

What are the experiences of veteran survivors with PTSD who utilize EFP for their recovery?

Sub-questions

1. How do veteran survivors with PTSD describe their experiences with EFP?
2. Does EFP benefit the recovery of veteran survivors with PTSD?
3. How do veteran survivors with PTSD describe the effects of EFP toward their recovery?
4. What treatments have veteran survivors with PTSD experienced prior to EFP?

Central Concepts and Phenomenon

In this study I explored the lived experiences of three veteran survivors with partial or full PTSD who participated in an EFP program. The theoretical framework for this dissertation was the client-centered approach as discussed in Chapter 2. The client-centered approach assumes that the client's phenomenology, constructive reality, and/or subjective experience is the basis from whence change can occur (Kensit, 2000). Client-centered theory also believes that it is the innate desire of every human to move toward greater self-actualization (Bozarth, 1997; Kensit, 2000). Client-centered therapists believe that the goal of therapy is not to inherently solve the client's problem but rather encourage them to move towards self-discovery, independence, and actualization through the use of congruence, empathy, and unconditional positive regard (Bozarth, 1997; Kensit, 2000; Lux, 2010; Rogers, 1959).

Role of the Researcher

My role in this study was that of participant-observer in the experiences of veteran survivors with partial or full PTSD who participated in an equine facilitated program. I was also

the primary investigative tool for the process. Client-centered theory espouses that individuals have the innate desire to "fully develop all potentialities that serve to maintain and/or enhance the individual (self-actualization)" (Kensit, 2000, p. 346). As the client is drawn toward self-actualization, he or she becomes open and flexible to both the inner and the outer experiences (Kensit, 2000). Therefore, the research within this study sought to understand the unique inner and outer experiences of veteran survivors, providing a voice to explore the unique struggles with partial or full PTSD and the subsequent journey toward recovery.

The idea for this study came from my own personal and clinical experience. I grew up owning horses and have personally experienced their curative powers. I have also developed and facilitated EFP groups for children and adolescent survivors of mental illness and/or abuse within the managed care system. Furthermore, I live in a part of the country where there is a high concentration of military bases (five within a 70 mile radius) and began to notice a recurrence of themes as a counselor in the managed care system. Clients described how they were impacted by a family member who was trying to make sense of PTSD and the struggle to find adequate therapeutic help (e.g. CBT, CPT, medications, etc.). After a thorough search of the literature I realized there was minimal research specifically exploring the lived experiences of veteran survivors with PTSD participating in an EFP program. I have over three years of experience working with EFP groups and sought out several ranches that work specifically with the veteran population, made the appropriate connections, and was able to discuss the study with the executive directors.

My direct experience with the power of horses and my long history as a horse enthusiast, owner, and rider could be a source of potential bias. Another source of bias could be my involvement in the planning, development, and execution of numerous EFP groups with children

and adolescent survivors of mental illness and/or abuse. Because of my own experiences with EFP, there is a need to address the potential biases that could arise. A set of specific self-reflection questions have been developed and the answers were reviewed by the members my dissertation committee for content and bias. The answers will be published in Chapter 5. The self-reflection questions are:

1. How will I know my interview questions are free of assumption or bias?
2. What assumptions do I have about EFP?
3. What assumptions do I have about the effects of EFP?

Methodology

Participant Selection Logic

The population for this study included veteran survivors with PTSD living along the Front Range urban corridor of Colorado and participating in an EFP program. The Front Range urban corridor is an area of Colorado that is located on the eastern slope of the Rocky Mountains and extends from Pueblo, Colorado in the south up to the Wyoming border in the north. As of 2012 the Front Range urban corridor consisted of 17 counties and approximately 4.4 million inhabitants (United States Census Bureau). According to the Defense Manpower Data Center (DMDC), Colorado, as of August 2013, has a total Department of Defense population of 61,569 with 37,285 active-duty service members. In September 2014, the Department of Veterans Affairs indicated a veteran population of approximately 413,271 in the State of Colorado. The Substance Abuse and Mental Health Service Administration (SAMHSA) stated that approximately 50% of returning service members seeks mental health treatment with about one-half receiving adequate and/or beneficial treatment. The Front Range urban corridor has about two-dozen ranches that provide some form of EFP for veteran survivors with PTSD.

Due to the population size, I used purposive criterion sampling to achieve the desired cases within the necessary boundaries. The criterion included veterans over the age of 18, who, met criteria for partial or full PTSD, and who were already participating in an EFP program along the Front Range urban corridor.

Instrumentation

In this qualitative inquiry, I, as the sole researcher, was be the primary instrument for investigation. Each participant was asked to participate in three points of data collection. First, a semi-structured interview with specific questions, based on the main research question and sub-question, was conducted. Second, specific observations of the participant's interactions with the therapeutic process were conducted. Finally, each participant was invited to participate in a photo interview. Each form of data collection was described in greater detail later in this chapter. Research protocols have been developed for each of the three phases of data collection. These protocols are based on the research questions and the selected theoretical framework.

Procedures for Recruitment, Participation, and Data Collection Plan

Participants were recruited through connecting with several executive directors and/or programs from therapeutic riding centers across the Front Range urban corridor that provide EFP. First, to ensure understanding, the executive director of each center was called and I was able to explain the framework of the dissertation. Second, of the fifteen centers called, four requested a letter of cooperation to be emailed to them. Of the four emails sent out, three signed letters of cooperation were returned. Third, I personally advertised the study to individuals or groups already participating in an EFP program. Potential participants were asked to make first contact so that appropriate informed consent and disclosures can be obtained, while maintaining the participant's privacy and confidentiality. The informed consent and disclosures informed the

participant that he or she can choose to end the study at any time without fear of repercussion. This study was advertised to three therapeutic riding centers in Southern Colorado, three therapeutic riding centers in the Denver, Colorado region, and three therapeutic riding centers in Northern Colorado. At the initial contact, participants were asked to complete a basic PTSD screening questionnaire called the Trauma Screening Questionnaire (TSQ). The TSQ is a 10-item symptom screening that is based off of the PTSD Symptom Scale. Participants were considered to have positive PTSD symptoms if they endorse at least six items (Brewin, 2002). The researcher chose a private, quite location at the ranch where the 60-90 minute semi-structured interview can be conducted with minimal distractions. Both informed consent and appropriate disclosures were thoroughly discussed at each of the face-to-face data collection phases. Each phase of the data collection process was appropriately described so that the participant had a clear picture of the observation and photo interview phases. The semi-structured interview were recorded on an MP3 player and then transcribed by DragonSpeak, a software service affiliated with Nuance. The completed transcripts were emailed to the participants for member checking (e.g. a review of content and accuracy). At the conclusion of the first face-to-face meeting, the second face-to-face observation was scheduled.

The second face-to-face observation was conducted at the specific therapeutic riding center where the participant received treatment. Field notes were taken and specific observations were recorded on an MP3 player, exploring the visual interaction between the veteran survivor and the equine. Similar to phase one of data collection, the recorded observations were transcribed by Dragon Speak.

The final face-to-face appointment included the use of a photo-interview. Using a photo-interview brought other components of the data collection together by allowing the participant to

speak into his or her own unique therapeutic process by reflecting on an important photograph, thus allowing for deeper meaning to be achieved. After the completion of the photo-interview, a detailed transcription of the three points of collection was written and then disseminated to the participants for final review. This final review asked the participants to member check (e.g. reflect on the content, check for accuracy of statements, and make the necessary corrections). Once the review was completed, participants were asked to return the transcript via email.

Interview Data. The initial interview was scheduled over the telephone, during the first point contact. The semi-structured interview was scheduled for 60-90 minutes to provide adequate time for the disclosure and informed consent to happen prior to the interview. The interviews were recorded by two digital MP3 recorders, so as to ensure accuracy and provide a back-up just in case one recorder failed. Both audio files were uploaded to DragonSpeak for accurate transcription. Creswell (2009) suggests that beyond the primary research question and sub-questions, approximately five interview questions are adequate for a semi-structured interview. These interview questions are in the interview protocol. Once the interviews were transcribed and reviewed for accuracy, they were uploaded into a secure and encrypted external hard-drive for storage and review of themes. The coding process sorted interview themes into specific categories, which will then be compared across cases to explore possible similarities and differences.

Observations. The observation was the second source of data for this study. Upon the completion of the first face-to-face contact, a time was scheduled were I was able to observe an EFP session. During the EFP session I observed at a distance, took hand-written notes, and recorded specific thoughts on an MP3 player. The goal of this phase was to capture the context of the lived experience of the veteran survivor while participating in an EFP session. Written and

recorded observations were transcribed and uploaded to a secure and encrypted external hard-drive for storage and for the coding of themes. Individual themes were then compared across participants for similarities and differences.

Photo Interview. The final source of data for this study was the photo interview. The photo interview invited participants to answer the research questions by taking a specific, meaningful, photo of the experience and then having them explain the photo(s) to the researcher (Kolb, 2008). The photo interview typically moves through four stages: (a) the participant is reminded of the main research question and then is asked to take a photo(s) that reflects his or her perspective on the question; (b) the second phase is the active phase where the participant takes his or her photo(s); (c) in the third phase, participants reflect on the photo(s) and verbalize his or her thoughts in an interview; and (d) the researcher analyzes the photo(s) and the recorded interview transcript (Kolb, 2008). This specific protocol was followed. The photo(s) were taken on a digital camera and viewed on my computer. The brief interview was recorded on an MP3 player and then uploaded to DragonSpeak for transcription. The collected data was then uploaded to a secure and encrypted hard-drive for analysis and coding. Themes were then compared to assess for similarities and differences.

Data Analysis Plan

Qualitative case study data analysis differs greatly from the structured, prescriptive analyses of quantitative research (Yin, 2014). Within the case study framework, the analysis depends on the researcher, his or her own style of thinking, the presentation of collected evidence, and the specific interpretations therein (Yin, 2014). For a case study researcher, data analysis is a continual and cyclical process that can begin at any stage and continue throughout the entirety of the process (Stake, 2006; Yin, 2014). The strategy of this collective exploratory

case study was to develop a solid, foundational, and descriptive understanding of the lived experiences of veteran survivors with partial or full PTSD who are actively participating in an EFP program. Furthermore, there was a triangulation of the four different points of collected data and then a comparison between the different cases to assess for meaningful themes (Stake, 2006; Yin, 2014).

Kensit (2000) indicated that the main assumption of client-centered theory is the importance of the client's subjective experience or phenomenology. Essentially, the constructed truth of the client should be viewed as reality, thus providing an accurate basis from whence therapy can begin. Therefore the singular lived-experience of the veteran survivor will be explored first through the within-case analysis of the interview, observation, and both points of the photo interview (e.g. participant and researcher analysis). Second a cross-case analysis explored the potential theme(s) between the different participants on all four data collection points. To assure analytic integrity, several specific techniques were utilized within case study research. Yin (2014) suggested the researcher use techniques such as time-series analysis, pattern matching, explanation building, and cross-case analysis to bolster the analytic credibility. This study will use thick description (primarily in the observation stage), within-case analyses (of all four data points), and cross-case analysis (of all four data points) to explore the presented themes.

Over the past decade, computer-assisted qualitative data analysis software (CAQDAS) has become more sophisticated, thus providing advanced, comprehensive tools for the specific dissemination of data (Yin, 2014). The use of CAQDAS provides the necessary assistance for data analysis, coding, and the storage of data in large qualitative studies (Yin, 2014). For this current collective exploratory case study I decided to utilize hand-coding procedures instead of

NVivo-10. Due to the limited and/or lacking data on EFP and veteran survivors with PTSD, I wanted to ensure that each point of collected data spoke for itself. Therefore, a broad-brush coding technique was used on each collected data point to develop an exhaustive list of codes (nodes). Second, a slicing coding method (Bazeley & Jackson, 2013) was used in the second round of coding, looking at the themes of entire paragraphs within the transcribed data. Codes were then categorized and put into themes.

Issues of Trustworthiness

Qualitative research is unlike quantitative research inasmuch as there are no statistical measures that can be applied to these subjective and constrictive viewpoints. To ensure the quality of a qualitative study, the use of trustworthiness is implemented as a tool to assess both reliability and validity (Morrow, 2005). Within the concept of trustworthiness, four specific domains emerge, they are: credibility, transferability, dependability, and confirmability (Rolfe, 2006). Credibility, similar to internal validity, explores the internal consistency of the research study (Morrow, 2005). This can often be achieved through prolonged exposure/engagement to the participants, participant checks, reflexivity, or deep observations (Morrow, 2005). Transferability, similar to external validity, explores the extent to which the study can be generalized (Morrow, 2005). This often refers to whether or not the study's procedures could be duplicated versus the extrapolation to a broader population (Yin, 2014). Dependability, the equivalent of reliability, focuses on the consistency through which the study is conducted (e.g. analysis, procedures, etc.) (Morrow, 2005). Finally, confirmability, or objectivity, is centered on the researchers objectivity (or lack therein), and the steps alleviate it (Morrow, 2005).

Credibility

To achieve credibility, several techniques were applied. First, prolonged exposure/engagement was utilized to ensure there was the necessitated contact with the participants. From this engagement, rich, thick descriptions were ascertained and recorded. The use of rich, thick descriptions added significant layers by exploring the participants' culture and context in the place where the experience was embedded (e.g. EFP ranch) (Morrow, 2005). This was achieved through several lengthy encounters with the participants, lasting between one and a half to two hours each time. Semi-structured interviews were conducted during the first contact, with the observation and photo interview happening at subsequent contacts. To ensure the highest credibility was achieved, participant checking occurred during the data analysis process. Participants were given transcripts of both interviews to verify for accuracy (Morrow, 2005; Stake, 2006; Yin, 2014).

Transferability

The intent of qualitative research is not to generalize the findings in a quantitative sense, but rather to adequately and accurately describe the themes developed within the context of the participants lived experiences (Creswell, 2009). Therefore this study utilized participant checking and debriefing to achieve transferability (Morrow, 2005).

Dependability

The measure of data over time and between methods and researchers is called dependability (Morrow, 2005). Dependability is tracked through a detailed audit trail, member checks, and peer reviews (Morrow, 2005). To ensure dependability, data triangulation was used through the expertise of the dissertation committee and through the three different data collection

points (e.g. semi-structured interviews, observations, and photo interviews). Furthermore, a detailed chronological account will be kept through the use of an audit trail (Morrow, 2005).

Confirmability

Confirmability deals with the amount of objectivity within the study. Morrow (2005) indicated that it is impossible to achieve 100% objectivity in a study, yet confirmability provides a step whereby the integrity and replication of the study is achieved. To maintain confirmability, researcher bias was discussed, research protocols were developed and followed, and an audit trail was kept to indicate where the data comes from to support the specific conclusions of the study.

Ethical Procedures

When conducting research, the utmost ethical standards must be upheld to protect the participants and the efficacy of the research. Section G of the American Counseling Association Code of Ethics focuses specifically on the guidelines for conducting ethical research (ACA, 2014). In section G.1., there is an exploration of the responsibility of the research to conduct research in an ethical manner, maintain confidentiality, and develop precautions to avoid participant injury (ACA, 2014). In section G.2., there is a discussion of the importance of informed consent, the rights of participants, client participation, and proper debriefing (ACA, 2014). In section G.3., researcher boundaries and relationships with participants are discussed and in section G.4. a description of the researcher responsibility to properly and accurately report the data are stated (ACA, 2014).

Reflecting on these ethical standards, several considerations arose. First was the confidentiality of the participants. Though there are numerous veterans in Colorado, there are only a handful of ranches providing EFP. Since this could hinder the integrity of the research, identifying information of the participants and of the ranches was removed. This ensured the

protection of the current participants, as well as, the protection of the viability of the therapeutic interventions of the ranch. There was the creation of a plan to properly equip, debrief, and care for participants should the need arise. To maintain the confidentiality of the participants, the data collected was transported in a locked fire-safe lockbox, stored in a locked fire-safe file cabinet, and adequately protected by passwords on the secure and encrypted external hard-drive. Finally, the participants were given a random number that was assigned to his or her paperwork to protect the identity of the participants.

Each participant was invited to participate in each of the three phases of the data collection (e.g. semi-structured interview, observation, and photo-interview), and consent forms were filled out by each participant at each stage of the data collection process. This ensured that if a participant dropped out for some reason, the data already collected could still be utilized and assessed to others in the study. Participants were properly debriefed and provided with a list of national and/or community resources that could continue to aid the participant in his or her progression toward recovery (e.g. practical and therapeutic). Finally, participants were allowed to review and correct the transcriptions of both interviews. All research documentation were stored for at least three (3) years after the completion of this study as determined by the Office for Human Research Protections (OHRP) (http://answers.hhs.gov/ohrp/categories/1567).

Summary

The quality of a qualitative study is directly related to the depth of the research plan (Yin, 2014). To ensure that the integrity of the study was upheld, the case study researcher considered all angles of the problem and created a study that provided a comprehensive inquiry therein. This chapter explored the fundamental concepts of the proposed study. In this study, a comprehensive inquiry was developed through the use of semi-structured interviews, detailed observations, and

photo interviews. Issues of trustworthiness (e.g. credibility, transferability, dependability, and confirmability) were carefully considered. I justified the decision to utilize a case study design, explained the participant selection process, and discussed the ethical components of this study, including the confidentiality and anonymity of the participants. Chapter 4 disseminated the data collected and the potential themes therein.

Chapter 4: Results

Introduction

This qualitative collective exploratory case study began as an inquiry into the lived experiences of veteran survivors with partial or full PTSD in relation to EFP. The collected data provided a much more in-depth picture into the lives of veteran survivors and their struggle to find the necessary support when working through PTSD symptomology. The central question of this study was to explore the experiences of veteran survivors with PTSD who use EFP for their recovery. I asked four subsequent subquestions to strengthen the central question. The four subquestions were:

1. How do veteran survivors with PTSD describe their experiences with EFP?
2. Does EFP benefit the recovery of veteran survivors with PTSD?
3. How do veteran survivors with PTSD describe the effects of EFP toward their recovery?
4. What treatments have veteran survivors with PTSD experienced prior to EFP?

Data collection, analysis, and results are presented systematically as they occurred throughout the trajectory of the study. The specific protocols, listed in Chapter 3, for interviews, photo-interviews, and observations were followed in all three cases. The setting and the demographics of the study are first presented to provide a clear context for overall study and this is followed by an in-depth description of the data collection procedures. Chapter 4 is divided into two data analysis sections. A within-case analysis was first conducted followed by a cross-case analysis, which assessed the potential themes between the three cases. I conclude this chapter with a discussion of trustworthiness and the results of the data analysis. Chapters 4 and 5 contain

direct quotes from the three participants. This enhanced and emphasized the specific themes found in the study.

Researcher Bias

In Chapter 3, I discussed the potential bias my direct experience with the power of horses and my long history as a horse enthusiast, owner, and rider may have on the study. I also discussed that another source of bias could be my involvement in the planning, development, and execution of numerous EFP groups with children and adolescent survivors of mental illness and/or abuse. Because of my own experiences with EFP, a structured self-reflection interview was used to allow me to address three specific questions about the aforementioned bias and the potential problematic effects therein. The impact of these biases on the data analysis process are fully discussed later in Chapter 4.

Self-Interview Questions

1. **How will I know my interview questions are free of assumption or bias?**

It is hard to fully separate myself from these biases. Instead of attempting to dismiss my assumptions and/or biases I readily embraced them. This allowed me to be fully honest with the participant about my past experiences with horses and how I view the process. I was very intentional not to allow my bias to influence the participant interview questions by only asking the pre-determined interview questions outlined in the interview protocol (see Appendix C). Therefore, I made sure that each question focused on the participants specific experiences from a purely objective frame of reference, thus any follow-up question asked was asked for clarification of participant statements only.

2. **What assumptions do I have about EFP?**

Growing up owning horses, I know the power that a horse can have, and I have personally experienced the healing qualities of the horse. This is not only an assumption I carry, but also a known fact among the horse community (Burgon, 2013; Cuypers et al., 2011; Drnach et al., 2010; Johansen, et. al, 2014; Kern et. al, 2011; Memishevikj & Hodzhikj, 2010; Snider, et. al, 2007; Tseng et al., 2013). I also assumed that my involvement with horses was similar to others experiences and/or that others experiences would mirror my own interactions. Specifically, when I was an adolescent, my horse was a calming place for me to safely express my emotions. Finally, I assumed that the participant-horse interaction would be an overall positive one but remained open to the potential that others may have an experience different from mine.

3. **What assumptions do I have about the effects of EFP?**

This was an important question for me to explore. Due to my past proficiencies in the development of EFP programs with children and adolescents, I wanted to make sure that this bias did not interfere with the data collection and analysis processes of the study. My first assumption is that EFP can be effective as an experiential alternative to traditional therapy. Time and time again I watched as the child and adolescent participants grew in emotional awareness, affect, communication, relationships, grades, etc. I also assumed that EFP would work across the diversity spectrum (e.g. age, gender, sex, race, etc.). Finally, I assumed that EFP was largely unheard of and used as a therapeutic last resort. However, I remained dedicated to objective consideration that participants could have experiences that were not aligned with my assumptions.

Setting

The Walden University IRB committee approved my dissertation proposal January 13, 2016; the approval number for this study was 01-13-16-0363554. Data collection began the second week of February 2016 and participant recruiting began by reaching out directly to veteran participants at the approved EFP center. Initially, two participants came from the first round of solicitation and the third participant was identified several months later during the second round of solicitation. Data collection progressed at the approved EFP center over the next five months. The other two approved sites were unable to yield any appropriate participants.

Initially there were several barriers to recruiting participants and collecting data during this stage of the study. At the time of IRB approval the Wounded Warrior Project was in the midst of an executive leadership change and, as a result, all funding for experiential therapies such as EFP, was frozen. This limited the scope of participant recruitment to one therapeutic group and two individual participants who were previously enrolled in the EFP program. The group participants declined to be a part of the study, while the two individual participants agreed, followed by a third individual participant several months later.

A second barrier was finding an appropriate place to conduct the interviews. It was originally thought that the participant would choose the interview site. However due to the possible lack of confidentiality of a public forum, it was determined that meeting at the ranch in a private office would be the best decision. Interviewing each participant at the ranch cut down on the possibility of extra commitment and contained the entire data collection procedure to approximately three hours per participant. The goal of three participants was achieved, and each participant provided a full set of data, covering all three data points.

Demographics

As previously described in Chapter 3, the population for this study included veteran survivors with PTSD living along the Front Range urban corridor of Colorado and who were already participating in an EFP program. The Front Range urban corridor is an area of Colorado that is located on the eastern slope of the Rocky Mountains and extends from Pueblo, Colorado in the south up to the Wyoming border in the north. As of 2012 the Front Range urban corridor consisted of 17 counties and approximately 4.4 million inhabitants (United States Census Bureau). According to the Defense Manpower Data Center (DMDC), Colorado, as of August 2013, has a total Department of Defense population of 61,569 with 37,285 active-duty service members. In September 2014, the Department of Veterans Affairs indicated a veteran population of approximately 413,271 in the State of Colorado. The Substance Abuse and Mental Health Service Administration (SAMHSA) stated that approximately 50% of returning service members seek mental health treatment with about one-half receiving adequate and/or beneficial treatment. The Front Range urban corridor has approximately two-dozen ranches that provide some form of EFP for veteran survivors with PTSD.

Participant Demographics

All participants resided in the aforementioned geographical region. All participants were originally from different parts of the county but chose to stay along the Front Range urban corridor upon discharge from her or his military service. All participants were enrolled in an EFP program prior to recruitment. One participant was 30 years old, while the other two participants were 40 years old or older (See Table 1). All names were changed to protect participant identity.

Table 1

Participant Demographics

	Gender	Age (y)	Race	Relation-ship status	Rank at discharge	Education	Branch and No. of deploy-ments	PTSD Dx	Tx
P1 (Monica)	F	53	PR	Separated	E5–E9	4-year degree	Navy w/2 deploy ments	Yes 1995	Coun/ Psych
P2 (Joyce)	F	45	Cau	Divorced	E1–E4	2-year assoc.	Army deploy ment N/A	Yes 2005	No
P3 (Aaron)	M	30	Cau	Divorced	E5–E9	Some college	Army w/3 deploy ments	Yes 2010	Coun/ Psych

Note. P=Participant. Y=Year. PR=Puerto Rican. Cau=Caucasian. F=Female. M=Male

Participant 1: Monica

Demographic. Monica was a 53-year-old Puerto Rican American veteran of the United States Navy. Monica's rank, upon honorable discharge, was between an E5-E9 (second level of enlisted ranking), with two deployments during her military career. She disclosed a formal diagnosis of PTSD in 1995 and has received some form of mental health services since the diagnosis. Monica indicates having some trade and vocational school training along with a four-year college degree. Monica is currently separated from her spouse.

Participant 2: Joyce

Demographic. Joyce was a 45-year old Caucasian American veteran of the United States Army. Joyce's rank upon honorable discharge was between an E1-E4 (lowest level of enlisted ranking), with no reported deployments. She disclosed a formal diagnosis of PTSD in 2005 and reported being in some form of therapy for the past 25-years. Joyce indicated having two associate degrees and has attended several years of traditional college. Joyce stated that she is divorced and currently single.

Participant 3: Aaron

Demographic. Aaron was a 30-year old Caucasian American Veteran of the United States Army. Aaron's rank upon honorable discharge was between an E5-E9 (the second level of enlisted ranking), with three reported deployments. He disclosed a formal diagnosis of PTSD in 2010 and reported being in numerous types of therapy since that time. Aaron indicated that he had gone to college but has not completed due to his PTSD. Aaron stated that he is divorced with one daughter.

Data Collection

Following the framework outlined by Yin (2014), several points of data collection were attempted in each case. Following specifically developed protocols, I attempted to collect three data points from each participant. Approximately one month after IRB approval I began reaching out to EFP ranches across the Front Range urban corridor. Once I was able to connect with the Executive Director of the ranch I was then able to meet with participants face-to-face and advertise the study.

Participant 1: Monica

Data Collection Procedures. Monica was the first participant to respond to the face-to-face recruitment and was the first individual to schedule the initial interview. After the initial face-to-face recruitment solicitation, Monica contacted me via phone call to set up the initial interview. Monica stated that she was "very excited to discuss her experiences with EFP." Monica and I discussed the parameters of the study over the phone and then made arrangements to conduct the 60-90 minute interview prior to her EFP session. Prior to conducting the initial interview, Monica agreed to all aspects of the study and signed the initial consent form. Monica and I agreed that each of the subsequent data collection points (i.e. observation and photo

interview) would happen on the same day so as to maximize her time and commitment to the study. The initial 60-90 minute interview took place at the ranch in a secure, private office. Following the interview, another consent form was signed and the 90-minute participant observation took place in a designated arena at the ranch. Finally, following the 90-miniute observation, another consent form was signed and the final photo-interview was conducted. The photo-interview required the participant to walk around the ranch and take a picture of something that was significant to them. Once the picture was taken we finished the interview in the same place that the initial interview was conducted, thus providing a private and safe venue for confidentiality.

Due to the back-to-back collection of data points, Monica was able to follow through with each required phase of the study. The interviews were recorded on two MP3 devices, the photo was taken with the researcher's iPhone 6s, and all three phases of data collection: the interview, observation, and photo-interview were transcribed using DragonSpeak by Nuance and then stored on an encrypted external hard drive. The transcript was emailed to Monica for review and she approved the text without corrections. All points of data, including the photo, were transferred to the encrypted hard drive for secure storage and analysis.

Trauma Screening Questionnaire. The Trauma Screening Questionnaire (TSQ) is a 10-item questionnaire that asks the participant to reflect on his or her personal reaction to the experienced traumatic event(s). If the participant answers yes to 6 or more of the 10 questions he or she is instructed to seek out counseling support as they are displaying Posttraumatic Stress symptomology. Of the ten items on the questionnaire, Monica answered yes to four items and no to six items, thus indicating partial PTSD symptomology. Monica indicated that she experienced:

1. Feeling upset by reminders of the event(s) at least twice over the past week.

2. Bodily reactions (such as fast heartbeat, stomach churning, sweatiness, dizziness) when reminded of the event(s) at least twice over the past week.
3. Difficulty sleeping or staying asleep at least twice over the past week.
4. Difficulty concentrating at least twice over the past week.

Participant 2: Joyce

Data Collection Procedures. Joyce was the second participant who agreed to be a part of the study. Joyce initially showed some reservations at the initial recruitment but then called me to discuss the confidentiality of the study. Joyce was told that though there could not be complete anonymity due to the venue (e.g. ranch), there would be complete confidentiality. Joyce stated that she was satisfied with that and agreed to be a part of the study. Joyce and I discussed the parameters of the study over the phone and then made arrangements to conduct the 60-90 minute interview prior to her EFP session. Prior to conducting the initial interview, Joyce agreed to all aspects of the study and signed the initial consent form. Joyce and I agreed that each of the subsequent data collection points (e.g. observation and photo interview) would happen on the same day so as to maximize her time and commitment to the study. The initial 60-90 minute interview took place at the ranch in a secure, private office. Following the interview, another consent form was signed and the 90-minute participant observation took place in a designated arena at the ranch. Finally, following the 90-minute observation, another consent form was signed and the final photo-interview was conducted. The photo-interview required the participant to walk around the ranch and take a picture of something that was significant to her. Once the picture was taken, we finished the interview in the same place that the initial interview was conducted, thus, providing a private and safe venue for confidentiality.

Due to the back-to-back collection of data points, Joyce was able to follow through with each require phase of the study. The interviews were recorded on two MP3 devices, the photo was taken the researcher's i-phone 6s, and all three phases of data collection: the interview, observation, and photo-interview were transcribed using DragonSpeak by Nuance and then stored on an encrypted external hard drive. The transcript was emailed to Joyce for review and she approved the text without corrections. All points of data, including the photo, were transferred to the encrypted hard drive for secure storage and analysis.

Trauma Screening Questionnaire. Of the ten items on the questionnaire, Joyce answered yes to five items and no to six items, displaying partial PTSD symptomology. Joyce indicated that she experienced:

1. Feeling upset by reminders of the event at least twice over the past week.
2. Bodily reactions (such as fast heartbeat, stomach turning, sweatiness, dizziness) when reminded of the event at least twice over the past week.
3. Difficulty falling or staying asleep at least twice over the past week.
4. Difficulty concentrating at least twice over the past week.
5. Heightened awareness of potential dangers to yourself and others at least twice over the past week.

Participant 3: Aaron

Data Collection Procedures. Aaron was the final participant to agree to participate in the study. Aaron was the most enthusiastic of the three and stated at the initial recruitment meeting, "Sign me up, I don't need to know the details, I just want to help veterans however I can!" Regardless of Aaron's enthusiasm, protocol was followed and Aaron was walked through the research process and procedures and an initial consent was signed at the first meeting. The

60-90 minute interview portion was scheduled for two weeks later as the ranch was taking a break to allow the horses to rest.

Prior to conducting the initial interview, Aaron was reminded of the policies and procedures of the study, agreed to all aspects of the study and signed the initial consent form. Aaron and I agreed that each of the subsequent data collection points (e.g. observation and photo interview) would happen on the same day so as to maximize his time and commitment to the study. The initial 60-90 minute interview took place at the ranch in a secure, private office. Following the interview, another consent form was signed and the 90-minute participant observation took place in a designated arena at the ranch. Finally, following the 90-miniute observation, another consent form was signed and the final photo-interview was conducted. The photo-interview required the participant to walk around the ranch and take a picture of something that was significant to them. Once the picture was taken we finished the interview in the same place that the initial interview was conducted, thus providing a private and safe venue for confidentiality.

Due to the back-to-back collection of data points, Aaron was able to follow through with each required phase of the study. The interviews were recorded on two MP3 devices, the photo was taken the researcher's i-phone 6s, and all three phases of data collection: the interview, observation, and photo-interview were transcribed using DragonSpeak by Nuance and then stored on an encrypted external hard drive. The transcript was emailed to Joyce for review and she approved the text without corrections. All points of data, including the photo, were transferred to the encrypted hard drive for secure storage and analysis.

Trauma Screening Questionnaire. Of the ten items on the questionnaire, Aaron answered yes to nine items and no to one item, displaying full PTSD symptomology. Aaron indicated that he experienced:

1. Upsetting thoughts or memories about the event that have come into your mind against your will at least twice over the past two weeks.
2. Upsetting dreams about the event at least twice over the past two weeks.
3. Acting or feeling as though the event(s) were happening again at least twice over the past two weeks.
4. Feeling upset by reminders of the event at least twice over the past week.
5. Difficulty falling or staying asleep at least twice over the past week.
6. Irritability or outbursts of anger at least twice over the past two weeks.
7. Difficulty concentrating at least twice over the past week.
8. Heightened awareness of potential dangers to yourself and others at least twice over the past week.
9. Being jumpy or being startled at something unexpected at least twice over the past two weeks.

Data Analysis

Originally, data analysis was going to be conducted with the use of Nvivo-10 software. However, due to only having three case studies to review, a request for change in procedures was submitted to the IRB and approved. Therefore, data analysis was performed by hand. The interviews, observations, and photo-interviews of each case were collected, transcribed, and stored on an encrypted external hard-drive. Three rounds of coding were conducted separately on each case. First, a broad-brush coding technique, as outlined by Yin (2014), was used on each of

the data points within each case to develop an exhaustive list of codes (nodes), which originated from the collected data. I reviewed the lists of codes in each data point and used the inductive process of collapsing and reordering to condense the current list of codes into categories. Second, a slicing coding scheme (Brazeley & Jackson, 2013) was used in which entire transcribed paragraphs were coded with multiple themes. A third round of slicing coding scheme was completed to determine if any new codes were missed. This did not produce any additional codes or categories.

A within-case analysis of individual data points (i.e. interviews, observations, photo-interviews, and researchers interpretation of photograph), were analyzed for common themes. Remaining true to the main assumption of client-centered theory the client's subjective experience was explored as truth and was viewed as his/her reality (Kensit, 2000). Each case yielded six to seven main themes unique to the individual case. After each within-case analysis was performed, a cross-case analysis was conducted to determine whether common themes existed between cases. The cross-case analysis compared the established categories/themes of the with-in case data to determine if there were any notable commonalities between the data points in each case. Several themes were consistent among each case and will be discussed in greater detail in the cross-case analysis results section of this chapter.

Results

The purpose of this collective exploratory case study was to discover the effects of EFP with veteran survivors with partial or full PTSD. Quintessential to the success of a collective exploratory case study is the specific research questions asked and creation of the interview questions there in. Each of the interview questions was derived from either the central research question or the sub-questions. The central question and sub-questions are stated below, followed

by a cognitive map created to illustrated the development between the research questions and interview questions; see Figure 1 below.

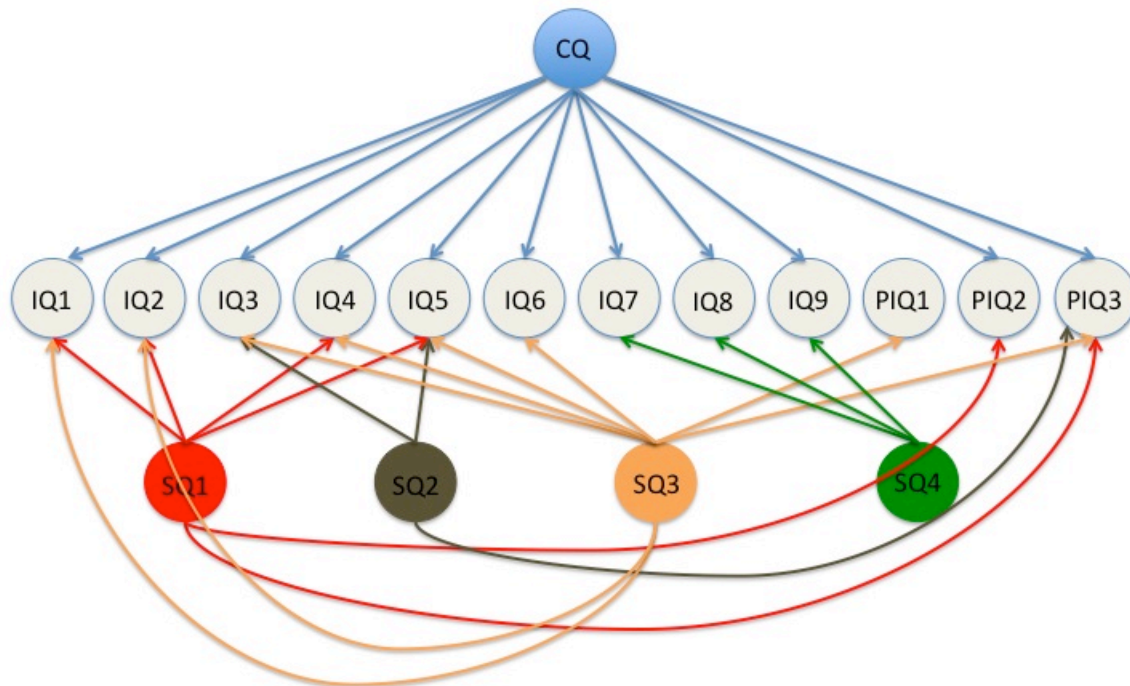
Research Questions

Central question

What are the experiences of veteran survivors with PTSD who utilize EFP for their recovery?

Sub-questions

1. How do veteran survivors with PTSD describe their experiences with EFP?
2. Does EFP benefit the recovery of veteran survivors with PTSD?
3. How do veteran survivors with PTSD describe the effects of EFP toward their recovery?
4. What treatments have veteran survivors with PTSD experienced prior to EFP?



Key: CQ: Central Research Question; IQ: Interview Question; PIQ: Photo-Interview Question; SQ: Sub-Research Question

Figure 1. Research Question – Interview Question Cognitive Map

Within-Case Analysis

Monica

Interview. The 60-90 minute initial interview took place at a discrete office space on the premise of the ranch. It was located in one of the barns, which provided Monica with the appropriate confidentiality. The weather that day was in the 30's and the make-shift heating did not fully heat the office space. Monica was asked if she wanted to post-pone the interview for a warmer day. She laughed and stated "you can never be certain as to the weather here…today is as good of day as any." Prior to the start of the interview, Monica was made aware of the

disclosures, agreed to the process and signed the initial consent form. The semi-structured interview consisted of nine-questions that were all linked back to the main research question and sub-questions (see Figure 1). The interview questions can be viewed in Appendix C. Monica indicated that she had been participating in EFP for over a year. She stated that prior to EFP she had attempted group therapy, PE therapy, EMDR, and psychiatry (with a prescription to "so many different medications it is unreal"). Monica stated that she had been significantly suicidal over her lifetime and had been placed on suicide watch numerous times. "Nothing seemed to work."

Monica stated that she found out about EFP through a newspaper advertisement and thought she would give it a try. "My experience has been awesome. When I first came here, I was newly out of the hospital from a suicide attempt…This experience has changed my life to the point where I can do almost anything." Six distinct themes arose from Monica's Interview; they are: communication, non-verbals, connection/relationship, selflessness (selfless awareness), choice, and increased mental health.

Communication. Communication appeared to be a key component to Monica's experience with the horse. She stated on several different occasions that the horse taught her how to communicate: "…I didn't know how to communicate, so I needed some way for communicating with the world." She also stated, "So she was going to have to teach me how to deal with the world." Then Monica exclaimed with tears in her eyes, "…I have learned to communicate with the outside world." Monica also indicated that the horse helped her learn to communicate with herself internally as well as stating her needs to those around her:

> "Vickie (horse) taught me how to deal with the world as well as my team. My team had a lot to do with that. They taught me how to breathe, how to see, how to see Vickie breathe,

> how she dealt with the world on a daily basis, what she wanted from humans, and what she needed from me…she taught me how to communicate."

With a smile on her face Monica stated:

> "Well, I went from being a mess to being someone who can stand up on her own two feet and tell you exactly what she needs, what she requires, and will not let anybody walk all over her again."

According to Monica, the horse helped her develop assertiveness skills, which allowed her to know when she needed help. Monica stated that because of this lesson, she was able to recognize when she was struggling and effectively communicate her needs to her therapist within session.

Non-Verbals. Similar to verbal communication, Monica's experience with the horse was largely made up of non-verbal interactions. Monica stated that her initial experience with Vickie (horse) did not involve verbal communication at all:

> "The horses were there and there was this one horse in particular that kept on chasing off the other horses and kept coming over to me. At that point I was crying…she kept coming and coming and um, I just put my hand on the railing…she'd come over and sniff my hand and then walk away…she did this over and over. I did not know her name at that point…but found out later her name was Vickie."

As the relationship progressed Monica became more in-tune to Vickie's non-verbals:

> "If I was having a hard time, my team knew, they were teaching me how to get Vickie to move in certain ways without a lead line, and that was pretty cool. And when they said I was having a rough time, Vickie knew, and I knew…when the relationship changed, I became more concerned about Vickie than myself."

After several months of coming to the ranch, Monica stated that she noticed a shift in Vickie, which prompted a change in her internal perspective:

> "Every week I came early so I could sit on that box to watch and just be. Vickie (horse) would come over and check on me…until one week I sat on the box and she just looked at me. She did not come over and check on me but just watched me…and the relationship changed…so I went to the pen and got her and there was a difference. I didn't need her to breathe for me anymore because I was able to breathe on my own…and she knew that. She knew, I knew, there was no longer any automatic panic."

Monica stated that as the therapy progressed she felt like her team (horse, therapist, and equine specialist) started to become one. They were able to communicate both verbally and non-verbally with ease.

Connection/Relationship. The reciprocal relationship became a very apparent theme as Monica shared her experience with Vickie (horse): "This is the only place I have not been judged. Animals don't judge. The people that work with them don't judge. They don't push you and they let you bond at your own rate." With tears in her eyes, Monica shared her initial experience with Vickie, stating that Vickie was keenly aware of her presence, her pain, and her fear, and chose to enter into relationship with her. Monica stated: "If I had to describe it to someone, I would say that her and I have an unbreakable bond, that she saved my life."

The reciprocal relationship became more evident when Monica described her experience of learning how to connect with the horse through a mindfulness exercise:

> "…and felt her and I breathed for the first time in a very long time. And once I did that, I relaxed and then she relaxed. The more she relaxed, the more I relaxed. We helped each

other. And it just was. And we did that for several weeks. And then the more I came, the easier it was to just be."

With the relational bond growing, Monica began to describe a selflessness that began to develop within her awareness. Monica described an instance where she came to the session distressed and as the session started she realized she did not want to involve Vickie until she was able to work through her distress. She stated: "When the relationship changed, I was more concerned about Vickie than myself."

Choice. Reflecting on the framework of EFP, Monica pointed out that the difference between EFP and other therapies is choice.

"I got to do it on my own terms. Actually on our terms, mine and Vickie's.

Someone wasn't telling me how to do it, or how they thought it should be done. It was at my own pace, not what they think the outcome should be up or what the book tells them."

This idea of choice was confirmed when Monica described a rough day she was having:

"When I was having a rough day, or when something happened in the pen that mad me upset, I was able to hand her off to the equine specialist and I would then go ask my therapist for help. This was the only place I could do that, it became my communication process…umm and we talked about it and we uh, and it felt like I was being forced to brush her just like I was being forced to do things in the rest of my life. I was given the choice to continue or to stop."

Increased Mental Health. A major theme throughout Monica's interview dealt with her increased ability to function. She was able to not only function better when she was around the horse, she stated that it also translated to her everyday life:

> "Well, I went from being a mess to being someone who can stand up on her own two feet and tell you exactly what she needs, what she requires, and will not let anybody walk all over her again."

Monica exclaimed:

> "My panic attacks are so infrequent…I may have one every month or month and a half, unless something really off the wall happens, but I can control them now."
>
> "I am more peaceful, I am more calm, I am more than elated, I have not found a word that can describe it…you have to experience it."

As Monica spoke, her countenance changed, she sat up in her chair and proudly stated:

> "It has changed my life to the point where I can do almost anything. I can go to the store and not worry about who is behind me or not…I'm not concerned with what other people are thinking or doing, I can sit in a restaurant and not have to sit in a corner, I can sit in the middle of the room and not have a care in the world. Um, I don't care if someone is judging me any longer, I don't judge myself. I don't live behind walls, I don't live in fear."

Observation. The observation took place immediately following the interview and lasted the length of the EFP session (approximately 90 minutes). Due to the structure of the ranch, it became difficult to protect participant anonymity, the risks were again reviewed, and Monica agreed by signing another consent form. To avoid affecting the session, I found a discrete observation point on a hay-bale about 30-feet from the round pen arena. Three main themes emerged from the observation field notes; they were: connection, communication, and selfless awareness.

Connection. The connection with the horse appeared to be a key component of the therapeutic process. This relational connection was displayed in several ways. The session started in the round pen with the Monica and Vickie (horse). The weather outside of the barn was cold and windy which caused the horse to be slightly agitated, as evidenced by her struggle to stand still with Monica. During the initial phase of the session, Monica chose to give Vickie room to move around, thus easing her distress. The connection during this initial phase of the session was demonstrated through a reciprocal relationship. Vickie would periodically look back at Monica, nudging her as if she was looking to her for guidance. In an attempt to calm Vickie down, Monica chose to walk Vickie around the arena. As the horse was led around the pen, she seemed to relax, as evidenced by the several deep breaths she took. After walking around the arena, Monica took time to connect with Vickie by placing her hands on Vickie's chest and torso. Monica took several deep breaths, which Vickie noticed and in-turn took a deep breath. As the observation continued, it was evident that Monica was calming Vickie down, and Vickie was calming Monica down. This reciprocal relational connection continued, and even deepened throughout the session. The culmination of the session took place when Monica took off Vickie's halter and lead line (tools used to lead the horse around) and walked around the arena with Vickie following her every move. As Monica walked, Vickie stayed in step with her, when Monica stopped, Vickie stopped, when Monica turned, Vickie turned. By the end of the session, they were doing figure eights with each other in the arena without using verbal commands. The depth of the connection between Monica and Vickie was palpable.

Communication. The theme of communication was largely determined by the non-verbal connection Monica and Vickie had. The strength of the communication process appeared to be derived from the strength of the reciprocal relational connection as aforementioned. First,

Monica was able to communicate her intentions with Vickie through her body language. When Monica led Vickie around the arena, she would communicate her intentions through her body posture. If she wanted to walk forward, Monica would stand up straight and walk with determination, to turn Vickie from left to right or right to left, Monica would maintain determination and lift up her hands in the direction she wanted to Vickie to go. When it was time to stop, Monica would slow her pace, slouch her shoulders and stop. Vickie received each of these physical commands as evidenced by her compliance. The second evidence of communication was Vickie's response to Monica. During different parts of the session, Vickie would look back at Monica and nudge her as if to playfully say "how are you", or "thank you". The third evidence of communication was Monica's ability to read Vickie's body language. Due to the weather, Vickie was often distracted by the wind, Monica noticed this distraction and was able to adjust her engagement with Vickie.

Selfless Awareness. The final theme from the observation could have been added to one of the aforementioned themes; however, there were several aspects that warranted a stand-alone theme. First, Monica's interaction with Vickie displayed a selfless maturity, this was evidenced by Monica's ability to read Vickie's body language and determine an alternative course of action. At one point in the session, Vickie was getting very agitated with the wind, instead of demanding that they continue in the activity, Monica noticed Vickie's agitation, stopped, and asked if they could get Vickie some hay to calm her down. Second, due to the wind and being away from her herd, Vickie would, at times, become distracted and walk away from Monica. Instead of controlling Vickie, Monica would allow Vickie the space to walk away, and then come back to the activity when she was ready.

Photo-Interview. The photo-interview took place immediately after the observation of the session. The photo interview invited participants to answer the central research question by taking a specific, meaningful photo of his or her experience and then explaining the photo through a series of three predetermined questions. Finally, the researcher provided an assessment of the photo as well.

Monica was, again, made aware of the inability to protect anonymity due to the need to walk around the ranch to find an appropriate picture. Monica understood and agreed by signing a final consent form. Once the protocols for the photo-interview were communicated, Monica immediately walked to Vickie's stall in the adjacent barn. She walked up to Vickie's stall and was greeted by a whinny after the greeting. Monica briefly connected with Vickie by caressing her neck. She then took a step back and took a picture of Vickie (see Figure 2)

.

Figure 2. Monica's photograph of Vickie

Once the photograph was taken, we walked back to the private office to finish the interview. Monica was asked three questions about the picture:

1. Tell me about the photo.
2. Why is this photo significant to you?
3. How does this photo represent the therapeutic experience?

Three themes developed from this photo-interview; they are: connection, non-verbal communication; and awareness.

Connection. Monica stated that this photo of Vickie reminded her of her therapeutic journey:

> "The day I came here I was very, very vulnerable and sitting on that red box by the pasture watching her chase everyone off and kept coming towards me. She was telling everyone that she was going to protect me and when we went into the middle of the pen she did the same thing and from that day forward, she has always protected me, and now we protect each other."

As Monica was talking, she began to tear up again. She was asked what those tears were about. Monica stated:

> "She made me strong, she taught me a lot, she will continue to teach me. I take the lessons that I learn here and use them every single day. I apply them to my everyday life. And that's how you learn and how you grow. And she is a representation of that for me. Vickie is life for me."

Non-Verbal Communication. Monica reflected on Vickie's posture in this photograph and stated:

> "Um, it reminds me of when I first came here and she was chasing off everyone else. Um, I'm strong willed, and I'm going to protect you, this is what she is saying to me."

Monica also noticed Vickie's immediate posture when we rounded the corner of the barn (which was under construction at the time of the photograph). Monica stated:

> "But when I came around the corner and she could see me and I could see her and feel her nervousness. It only took a few minutes for me to calm her and she knew it would be okay as long as I was there."

Awareness. The theme of awareness ties in very closely with the previous theme, yet, needs to be a stand-alone concept, inasmuch as Monica could have very easily demanded a

photograph from Vickie in her agitated state. Instead Monica was able to recognize Vickie's distress and felt the need to calm her down prior to the photograph.

Researcher Interpretation of Photograph. Reflecting on Monica's photograph of Vickie, several concepts stood out. First, Monica was asked to take a photograph of something significant to her at the ranch; she was not instructed to take a photograph of the horse. The fact that she chose to take a photograph of Vickie confirms the depth of the reciprocal relational connection between the two of them. Second, was Vickie's posture in the photograph. Walking up to the stall with Monica, Vickie had her ears pinned back, which is a sign of agitation. Monica recognized her distress and took several minutes to connect with her prior to taking the picture. Vickie's posture in the photograph is one of curiosity and relaxation, as evidenced by her ears and her eyes (both focused on Monica who as taking the picture), and her neck placement (slightly lowered, which signifies relaxation).

Monica's Within-Case Themes. The within case analysis of Monica's case produced several key common themes. Key themes from each data point are shown in Table 2, with the common themes aligned.

Table 2

Key Themes From Each Point of Data Collection (Monica)

Type of data collection	Themes					
Interview	Communication	Connection/ relationship	Selflessness	Nonverbals	Choice	Increased mental health
Observation	Communication	Connection	Selfless awareness			
Photo-interview	Nonverbal communication	Connection	Awareness			
Researchers interpretation of photograph	Nonverbal communication	Connection/ relationship	Awareness			

Joyce

Interview. Joyce's 60-90 minute interview took place in a discrete office space in one of the smaller barns. The weather that day was foggy and in the 20's. The room was heated by two space heaters, thus making it difficult to properly hear during the interview. Joyce was asked if she was okay with turning the heaters off so that the interview could be more enjoyable, and if she became cold, we could take a break and heat the room back up again. Prior to the start of the interview, Joyce was made aware of the disclosures, agreed to the process and signed the initial consent form. The semi-structured interview consisted of nine-questions that were all linked back to the main research question and sub-questions (see Figure 1). The interview questions can be viewed in Appendix C. Joyce stated that she had only been coming to her EFP sessions for several sessions, but was glad to try something new and different. Joyce reported that prior to EFP she had been in group sessions for five years, tried EMDR, anger management classes, art therapy, and medications. She stated, "I've been in some sort of therapy for over 25 years." Four themes developed from Joyce's interview. They are: congruence, decompression, connection/relationship, and awareness.

Congruence. Reflecting on her initial experience with the horse she recognized the importance of being present in the here and now, which forced her to be congruent with her emotions. Joyce stated:

> "In the real world I can put a mask on. I've been through therapy for years and never talked about my issues until the past year, even through intense trauma therapy. This has been such a different experience…even in my first session, you have to focus on breathing and keeping your heart rate low. I can be calm on the outside but a mess on the inside, and this does not work with the horse."

As Joyce shared her experience, she became visibly calmer as she talked.

> "You don't focus solely on yourself and you have to think about the horse. Almost worry about the horse because the horse is so powerful that you have to be concentrating on them and how they are doing and how they are going to react to you so you have to keep yourself calm so it is a very different experience because you have to keep yourself in check. Because you don't want the horse to have a bad reaction to you, freak out and hurt you."

Joyce continued to reflect on her experience and seemed to be fascinated by Oliver's (horse) ability to respond to her. She reported: "You have to focus on breathing and keeping your heart rate low." She took a deep breath as she indicated:

> "Oliver is easily relaxed by me, I must be doing something right. It is nice to know that you can easily relax a horse and have a nice connection with them. You get that instant feedback and affection. It is really nice."

Joyce expressed the need for congruence in the here and now processing:

> "Me taking care of the animal, I am able to discuss things about myself and see things about myself as I work with the horse."

Decompression. Throughout the interview Joyce described her experience with Oliver as a form of yoga. She stated: "I think it is a form of yoga. It decompresses me." She went on to say,

> "Um, well like I said, I feel decompressed when I leave here and there is this unspoken thing and I have to literally get my heart rate down and relaxed so he is not anxious…I guess this somehow affects it that way because I am always normally tense

and always have a heightened awareness and scheming. I try not to do that but this (equine therapy) helps bring it down."

Furthermore, on several occasions during the interview Joyce stated that the therapeutic process is "relaxing", and that she "really liked the experience since I have stopped traditional therapy."

Connection/Relationship. A prominent theme throughout the interview was Joyce's connection with Oliver: "I just like to hangout with the horse, do light grooming and be close to the horse. To me, just being close to the horse is very cathartic." She went on to relay, "It is good to be one with the horse…it is good to hang with the horse." Joyce shared her perspective on the client-horse relationship by stating:

> "Um, I am kind of drawn to the horse because I am a bit afraid of the horse…I am not really afraid of anything…I am normally an alpha personality. I am not really afraid of much. But with the horse, they intimidate me and this is a good way for me to get over my fear…Oliver is the only horse I've connected with and from very early on he has a very intentional connection with me and that was very nice for me because I am afraid of them I've seen what they can do. It is nice to have a connection with a powerful animal."

Awareness. The final theme derived organically from the interview process was this idea of awareness. This appeared to become a reciprocal process between Joyce's internal process and external awareness. She reported, "I find myself drawn to the horse, so that has been different for me…so far it's working out pretty well because I have a care taker type of personality. It works out well for me."

As she retold her experience with Oliver, Joyce sat forward in her seat as if to lean in to the conversation, concentrating on the specific details.

"…you have to be concentrating on them and how they are doing and how they are going to react to you so you have to keep yourself calm. So it is a very different experience because you have to keep yourself in check…because you don't want the horse to have a bad reaction, freak out and hurt you."

Joyce continued by stating:

"My horsemanship is terrible, but I am not sure as to my progression…I just know that when I leave here…whether or not it was a good day with the horse…I am okay."
"Sometimes I feel for the horse…so that's okay…so, I see it as a good experience,
I know that this is making me a better person in my growth, I don't want to be someone who is dependent on therapy and medicine, and working with Oliver is helping me."

Observation. The observation took place immediately following the interview and lasted the length of the EFP session (approximately 90 minutes). Due to the structure of the ranch, it became difficult to protect participant anonymity, the risks were again reviewed, and Joyce agreed by signing another consent form. To avoid affecting the session, I found a discrete observation point on a golf cart 40-feet from the round pen arena. Three main themes emerged from the observation field notes, they are: connection congruence, and decompression.

Connection. The need for connection between Joyce and Oliver (horse) was very evident. Oliver was removed from his herd and was distracted by the poor weather outside. Oliver's distractions appeared to directly affect Joyce. The therapist had Joyce stand with Oliver in the middle of the arena for about twenty minutes, allowing Oliver to move around. On several different occasions, Oliver would come up to Joyce, stop, sniff her hand and then go back to walking around the arena. After twenty minutes, Oliver stopped near Joyce. Joyce was then able

to walk up to Oliver and started talking to him. While she was talking to him, she removed her hands from her pockets, which appeared to calm Oliver down even more as evidenced by a big exhale. Once Joyce removed her hands from her pockets, Oliver took several steps closer to Joyce. Joyce continued to talk about her week and her experiences as she placed her hands on Oliver's chest and torso. The more Joyce talked, the more the both of them were able to calm down and regulate her inner state as evidenced of the relaxing of shoulders, and several deep breaths taken.

Congruence. The need to be present in the here and now and congruent with one's self became an apparent major theme in Joyce's experience. Joyce began the therapy session very reserved with her hands in her pockets. Joyce kept saying that the horse seemed distracted. Her therapist related the distraction back to Joyce. She disclosed that she had a migraine and that there was an issue at home prior to coming to the session. *"I am slightly out of it today."* As Joyce disclosed her internal distractions, Oliver stopped fidgeting and stood quietly and calmly next to her. Throughout the session Joyce's therapist encouraged her to explore the awareness of her own anxiety in relation to the horse. She was asked to consider what made Oliver anxious and if there was any correlation to her own life.

Joyce's therapist spent time discussing her need to be congruent and how her honest representation of her internal state would alleviate the horses concern of harm. The majority of the session was focused on Joyce becoming fully present with the horse. When she removed her hands from her pockets and started to talk to the horse, the horse went right up to her and stood next to her until Joyce was able to fully regulate. The therapist asked Joyce what she was feeling and she disclosed a *"warmth of nerves in my chest."* Client reported a feeling of hypervigilance because the horse was so big and she felt as if she needed to protect herself. Joyce's therapist

encouraged her to talk to share her feelings with the horse, and as she did, both, she and the horse relaxed. Joyce's therapist further discussed congruence and the importance of the inner state and the outer-self matching each other. While this interaction was taking place, Joyce let out a deep breath and calmed down and several seconds later Oliver let out a deep breath as well.

Both the idea of congruence and being in the here-and-now relied on Joyce's ability to be aware of her surroundings, aware of Oliver (both physically and emotionally), and aware of her own internal state. Several times throughout the session Joyce was asked to relate and/or attempt to understand Oliver's behaviors. Furthermore, Joyce was constantly asking the therapist what Oliver was doing, and made several suggestions as to how he was feeling. Though congruence of self is the key theme, both here and now processing and awareness were bookends to the experience.

Decompression. This was an interesting theme and one that could not have been combined with another theme. Throughout the entirety of the session there was a mutual reciprocity between Oliver and Joyce. If Oliver became worked up, Joyce started to get agitated and vice versa. However, when Joyce's attention was brought to how she reacted to Oliver, she appeared to be able shift her thinking, take control of the situation and calm down. Every time this happened she was able to take a deep breath, which allowed Oliver to take a deep breath. The best way to describe the interaction was that it was like watching someone letting the air out of a tire. The anxiety appeared to dissipate calming both Joyce and Oliver down.

Photo-Interview. The photo-interview took place immediately after the observation of the session. The photo interview invites participants to answer the central research question by taking a specific, meaningful, photo of his or her experience and then explaining the photo

through a series of three predetermined questions. Finally, the research will then provide an assessment of the photo as well.

Joyce was, again, made aware of the inability to protect anonymity due to the need to walk around the ranch to find an appropriate picture. Joyce understood and agreed by signing a final consent form. Once the protocols for the photo-interview were communicated, Joyce immediately walked outside to find Oliver. After the completion of the therapy session Oliver was released back into the pasture to reconnect with his herd (see Figure 3).

Figure 3. Joyce's photograph of Oliver.

Once the photograph was taken, we walked back to the private office to finish the interview. Joyce was asked three questions about the picture:

1. Tell me about the photo.

2. Why is this photo significant to you?
3. How does this photo represent the therapeutic experience?

Though Joyce's responses were short, three themes developed from this photo-interview, they were: decompression, connection, and here-and-now.

Decompression. Discussing the picture, Joyce reiterated: "I describe it like a form of yoga." She went on to state:

> "To me it is a tranquil scene…I've had that in one of my therapy sessions before where I get stressed out I have a picture of a serene cabin where I grew up and that's always a photo I go to when I am stressed…Oliver has become one of my favorite things now…he is very peaceful to me…this photo will be a great reminder of that. I equate Oliver to a peaceful tranquil thing."

As Joyce was reflecting on the photograph she took several deep breaths and settled into her chair. She continued by reflecting: "Um, I see Oliver who is a nice horse, hanging out in a peaceful scene and um it is just a calm representation for me."

Connection. Joyce looked at the picture and responded: "This reminds me of the first session. When you start therapy they have the horse one that stayed with me."

Here-and-Now. Reflecting on her therapeutic process, Joyce stated:

> "I don't see it as therapy, I see it as a cathartic expression. This whole experience is on a different level than therapy. You have to work on your struggles in the moment or the horse won't interact with you."

Researcher Interpretation of Photograph. Reflecting on Joyce's photograph of Oliver I was intrigued by the serenity of the picture. Joyce stated numerous times that Oliver represented calm or peace for her. Looking at this photograph makes me want to take a deep breath as it a

displays peace. The horses are calm and resting and yet they are facing each other and connected. The mist in the background draws you into the here and now and has a deep calming effect as well. It is peaceful.

Joyce's Within Case Themes. The within case analysis of Joyce's case produced several key common themes. Key themes and sub-themes from each data point are shown in Table 3, while the common themes are aligned in each column.

Table 3

Key Themes From Each Point of Data Collection (Joyce)

Types of data collection	Themes			
Interview	Congruence	Decompression	Connection/ relationship	Awareness
Observation	Congruence	Decompression	Connection	
Photo-interview	Here-and-now	Decompression	Connection	
Researchers interpretation of the photograph	Here-and-now	Peace/ decompression	Connection	

Aaron

Interview. Aaron's 60-90 minute interview took place in a discrete office space in one of the trailers on the property. The weather that day was partly cloudy and in the 80s. The room was hot and Aaron asked if we could open up the windows for a cross breeze. Prior to the start of the interview, Aaron was made aware of the disclosures, agreed to the process and signed the initial consent form. The semi-structured interview consisted of nine-questions that were all linked back to the main research question and sub-questions (see Figure 1). The interview questions can be viewed in Appendix C. Aaron stated that he had only been coming to his EFP sessions for several weeks but was glad to try something new and different. Aaron reported that, prior to EFP he had been inpatient treatment for substance abuse, tried EMDR, CPT, and has participated in

"a lot of group therapy." Six themes developed from Aaron's interview. They were: unconventional, respect, non-verbal communication; trust; and here-and-now.

Unconventional. Aaron characterized his experience with EFP as an *"unconventional one"*. This phrase was repeated on several different occasions throughout the interview. Aaron described his therapy as:

> "It is unconventional. I like that it is outside, that you are working for animals. The only thing I know when I get ready for the appointment is that I will be working with a horse. You never know what is going to happen that day, you never know how the interaction with the horse will go."
>
> "Even with other therapy that I have been in, and liked, this is the first one that I've enjoyed and looked forward to on a consistent basis. I've never been asked to recall any of my trauma."

Aaron explained that the reason he sees this as unconventional is due to the context and processes of the therapy itself. He stated:

> "The fact that it is outside, it kind of relaxes me because I don't feel like I am stuck in an environment that I don't want to be in…I felt in control of my environment and have several different options within the session if one didn't go well."
>
> "I am not dreading the fact and wondering if it will be a good session because someone in the group therapy session is not having a good day and you have to listen to their problems, making the therapy a waste of time. Here (with the horse) it is not like that."
>
> "There is really no comparison to other therapies. I would recommend it to veterans. The more severe their PTSD is, the more progress they would make in this

therapy. Instead of being reactive therapy or a last resort, this should be a therapy that they go to first…because if I had something like this in the beginning, then going to some of the other therapies would have not been so bad because when those things came up I would have had a foundation where I could better cope and tools that I could draw from."

"Sometimes in regular therapy you talk about things that trigger you and you have to figure out how to deal with them for the next week…the hypervigilance comes back, the perimeter checking comes back and this (equine therapy) does not do that to me."

Respect. An important part of therapy for Aaron was respect. He indicated that there should be mutual respect between him and the horse. He elaborated by stating:

"It is a respect thing because they are so powerful. At any time they could just trample you if they wanted to…having that knowledge makes the respect present and when interacting with the horse it is a good thing when you are able to make a bond with the animal."

Aaron also stated that:

"Like during the session today when he was interested with what was going on in the stall…instead of making him come out, I went in and connected with him and then came back out. Eventually he followed me, that kind of stuff feels good because you feel that kind of bond growing and the trust developing…you need to respect them."

Non-Verbal Communication. Throughout the interview, Aaron indicated that he struggled with conventional therapy because you had to talk about the experienced trauma. He also stated that talking in general was difficult. Aaron reflected on the non-verbal communication needed to make his equine therapy a success: "The connection you build with them is a non-verbal

agreement for trust and for respecting boundaries…I think that a lot of the non-verbal work is sometimes more impactful than the words that you can say…It is the non-verbal connection, understanding boundaries, and respecting them." Reflecting on the actual therapeutic sessions and his non-verbal experiences, Aaron stated:

> "The second time it was me meeting and connecting with Jake (horse). It was feeding time and he was a bit distracted so we took him out to eat grass and as I spent time with him he started to calm down…and then he was more receptive to the relationship."
>
> "He was a bit anxious and we tried to do connection exercises but I was a bit jumpy and could not keep my eyes closed at all. And there were times that he was trying to go a different direction than he was supposed to go and made some quick movements, which put me on edge."

Aaron reflected that he not only had to pay attention to his own non-verbal communication, he had to be keenly aware of Jake's non-verbal cues as well.

Trust. Aaron conveyed in the interview that trust is a difficult thing for him to develop, yet it is a key component to the equine therapeutic process. He stated:

> "It is a trust thing. Trust comes hard to me as it comes hard to a lot of veterans…unless you've experienced some of the same things you don't easily get trust. With animals it's not an issue of whether I can trust you or if you get my trust…if I do this and interact this way I will get the trust, which will allow me to trust the animal and if I don't do these things I won't get their trust and they won't like me and I won't get their trust."

Aaron reflected on his current treatment goals and reported that trust in the therapeutic process and in the therapeutic setting was a huge part of his current success:

"Well one of my treatment goals was to try to lessen the impact of leaving my house because some days it is debilitating to leave the house and there are days where I just don't want to walk out the door. I don't know what is going to happen when I walk out the door but I am almost certain something bad will happen. I've already started to see change with that…because I look forward to coming to the ranch to interact with the horse as it is one of the highlights of my week…there is no struggle in coming here."

Here and Now. Aaron stated that his experience in EFP has been considerably different than other therapy:

"Well, grounding techniques have given me a lot of foundation to hold it together when I start to freak out. As a matter of fact, I did not tell my therapist this, but I had a pretty bad anxiety attack and was able to think back to the connecting exercises with Jake (horse) and being able to have my hands on the horse and breathe…I was able to focus on my breathing and that helped me get through that and grounded me."

As Aaron shared his experiences with the horse, his physical countenance shifted from being stiff and rigid to calm and relaxed. He continued:

"Um, I think that uh, some of my most remarkable experiences with therapy is the ability for me to center myself. It is kind of an unconventional approach and I was not expecting as much of a reaction to it. The first time I came to the therapy, they were having a shooting competition in the arena next to the barn as we were trying to do therapy, which obviously put me on edge. But the fact that I was not freaking out and run away and was able to get something from the therapy spoke a lot to me about the potential that it had."

"They (therapist) ask me to stay present in the moment and focus on the here and now…we work on things/triggers and how to cope with them in the moment."

Observation. The observation took place immediately following the interview and lasted the length of the EFP session (approximately 90 minutes). Due to the structure of the ranch, it became difficult to protect participant anonymity, the risks were again reviewed, and Aaron agreed by signing another consent form. Due to other activities taking place at the ranch that day, the session took place in the outside portion of Jake's (horse) stall. To avoid affecting the session, I found an observation point on a fence about 15-feet from the stall. Four main themes emerged from the observation field notes, they were: non-verbal, communication, trust, and here-and-now.

Non-Verbal Communication. The therapeutic session started as the therapist and Aaron walked up to Jake's stall. Aaron was asked to read the horses body language in relation to the other horses in the area. A discussion with the therapist about the importance of body language in relation to communication between humans and horses is very similar between humans. Aaron realized Jake's anxiety based on his body language and his unwillingness to come out of the stall. The therapist asked Aaron if he would mind respecting the horse and stay in the stall for therapy instead of taking Jake out. Aaron agreed and went into the stall to begin connecting with Jake in an effort to calm himself down. Several times thereafter, Jake communicated agitation with the surrounding distractions and Aaron was able to read the non-verbal communication and react accordingly.

Trust. Throughout the session, there was displayed a mutual and reciprocal trust between Aaron and Jake. Once outside of the stall, Jake displayed calmness and trust with Aaron by leaning his head into Aaron's chest as he brushed Jake's mane. Trust was also displayed in Jake

always returning to Aaron's side. Several times throughout the duration of the session, Jake would hear a noise, leave to go check it out and then come back and stand with Aaron.

Here-and-Now. Somewhat similar to the theme of non-verbal communication is the theme of being present in the here and now. Throughout the session, Aaron was challenged by the therapist to pay attention to his body's internal cues in relation to the horse's response. Aaron was asked if his anxiety/PTSD surfaced, what he would need to do to calm down. Aaron was able to discuss several coping skills learned in previous session. During the discussion about coping skills, Jake began to show signs of agitation and ended up putting Aaron in a corner, which activated his hypervigilance. As Jake walked away, the therapist was able to use the previously discussed coping skills to help Aaron center himself. Once calm Aaron went into the stall where Jake was and was able to help Jake calm down as well.

Photo-Interview. The photo-interview took place immediately after the observation of the session. The photo interview invites participants to answer the central research question by taking a specific, meaningful, photo of his or her experience and then explaining the photo through a series of three predetermined questions. Finally, the researcher will then provide an assessment of the photo as well.

Aaron was, again, made aware of the inability to protect anonymity due to the need to walk around the ranch to find an appropriate picture. Aaron understood and agreed by signing a final consent form. Once the protocols for the photo-interview were communicated, Aaron walked outside to find Jake. Aaron found Jake in the outside portion of the stall where the therapy session previously took place (see Figure 4).

Figure 4. Aaron's photograph of Jake

Once the photograph was taken, we walked back to the private office to finish the interview. Aaron was asked three questions about the picture:

1. Tell me about the photo.
2. Why is this photo significant to you?
3. How does this photo represent the therapeutic experience?

Though Aaron's responses were short, three themes developed from this photo-interview, they were: respect, trust, and here-and-now.

Respect. Aaron reflected on his picture and stated:

"The power of the animal…there was a couple of times that I could feel the fence on my back and Jake was leaning into me."

"Instead of being around him at all times, which is okay because I felt like it was good for both of us to separate and then reconnect and to this throughout therapy so that neither one of us felt as if there was constant pressure on either of us."

"Jake decided to come out for his close up…this is how the therapy went. He makes decisions when he wants to react and when he doesn't want to interact. I feel this is significant for he and I in therapy…I think there should be a certain amount of time for both of us to have space from each other as well as working with each other."

Trust. Aaron's desire for mutual trust was evident in his response to this picture. He stated:

"Well the reason that I wanted to take a picture of the pen is this was the first session that we were inside…so it was a little bit more confined quarters and it took a little more trust for me not to bust out of the stall. There were a couple of times where I was up against the gate with the other horse..."

"So it took a lot of trust in him not to slam me against the pen…it also caused me to be aware of my surroundings and how I was moving around him."

Here and Now. The final theme of this picture was Aaron's need to remain in the moment with Jake.

"This picture is a good reminder that the pen was the most significant thing because if something went wrong I couldn't escape which is always at the back of my mind. I had to stay present and work through it."

Aaron also reflected on his most recent session and being cornered between Jake and the gate:

"I'm like remaining calm knowing that it is going to be okay which is the purpose of the grounding exercise which is a significant thing to go through in therapy as far as

not letting that boxed in feeling make you feel irrational and make decisions that would end up hurting you and the horse."

Researcher Interpretation of Photograph. Reflecting on Aaron's photograph of Jake I was intrigued Jake's position in the stall. When we walked up to take the picture Jake was inside his stall, but when Aaron walked up, the horse came out. Jake and Aaron spent the majority of the therapy session in the exact spot where Jake is standing. The bars on the fence almost seem symbolic of Aaron's current journey. The bars on the fence could represent his current struggle with his anxiety and PTSD, while Jake represents his ability to find connection and grounding.

Aaron's Within Case Themes. The within case analysis of Aaron's case produced several key common themes. Key themes and sub-themes from each data point are shown in Table 4, while the common themes and sub-themes between each data point are aligned in each column.

Table 4

Key Themes From Each Point of Data Collection (Aaron)

Types of data collection	Themes				
Interview	Unconventional	Respect	Nonverbal Communication	Trust	Here-and-now
Observation			Nonverbal Communication	Trust	Here-and-now
Photo-interview		Respect		Trust	Here-and-now
Researchers interpretation of photograph	Connection	Respect		Trust	Here-and-now

Cross-Case Analysis

The aforementioned within-case analysis section provided the three individual cases in a rich and detailed descriptive language. The within-case section provided a unique framework of the lived experiences of veteran survivors with partial or full PTSD who utilized EFP for their

recovery. This next section, the cross-case analysis, will explore the similarities and differences of the interviews, observations, photo-interviews, and researchers interpretation of the photo-interviews through the lens of Roger's Client-Centered Theory, which is the theoretical framework for this study.

Demographic Similarities

During the within-case analysis write up of the participant demographics, several similarities emerged. First, all of the participants were enlisted military. Joyce and Aaron were enlisted Army, while Monica was enlisted Navy. Second, all of the participants carried a formal military diagnosis of PTSD, with each participant being in some form of therapy for years. Third, all three participants were either separated or divorced from their spouses. Fourth, all of the participants had some form of post-high school education. Finally, two of the participants, Aaron and Monica, reported multiple deployments with Joyce reporting zero.

Trauma Screening Questionnaire Similarities

The Trauma Screening Questionnaire is a Public Domain measure created by Brewin (2002) and was utilized to screen participants for partial or full PTSD symptomology. Participants were asked to read through the ten questions and indicate (yes or no) whether or not they had experienced any of PTSD symptoms twice within the past week. Monica answered yes to four of the ten questions showing partial symptomology. Joyce answered yes to five of the ten questions showing partial symptomology. Aaron answered yes to 9 of the ten questions showing full symptomology. All three participants answered yes to three questions:

1. Feeling upset by reminders of the event at least twice over the past week.
2. Difficulty falling or staying asleep at least twice over the past week.
3. Difficulty concentrating at least twice over the past week.

Cross-Case Themes

The coding of each data collection point was conducted specifically within each case, and more specifically with in each data collection point (e.g. interview, observation, photo-interview, and researchers interpretation of photograph). This was purposively created so that the data collected in each case would provide an explanation of the participant's subjective experience within that unique portion of the study. For the purpose of the cross-case analysis, each point of data collection within the cases was reevaluated. First, a broad-brush coding technique was used to develop an exhaustive list of codes (nodes) within each point of data collection (Bazeley, & Jackson, 2013; Stake, 2006; Yin, 2014). Second, transcribed paragraphs were then reevaluated and coded with multiple themes. Third, the codes (nodes) were re-categorized within each point of data collection. Finally, key themes between each point of data collection were identified to describe the commonality between each participants experience.

Interviews. Reviewing Monica, Joyce, and Aaron's interviews, 18 codes were generated: respect, trust, non-verbal communication, here-and-now, awareness (internal and external), unconventional, enjoyable, relaxing, safe, reciprocity, connection, coping skills, relationship, selflessness, calm, decompression, release, and choice. From these 18 codes, 4 categories were developed: here-and-now, decompression, relationship, and communication. Finally, from the 4 categories two themes emerged: here-and-now processing and relational connection. See Table 5 for the breakdown.

Table 5.

Codes/Nodes, Categories, and Themes for Participant Interviews

Codes/Nodes	Categories	Themes
1. Respect 2. Trust 3. Non-Verbal Communication 4. Here-and-now 5. Awareness (Internal and External) 6. Unconventional 7. Enjoyable 8. Relaxing 9. Safe 10. Reciprocity 11. Connection 12. Coping Skills 13. Relationship 14. Selflessness 15. Calm 16. Decompression 17. Release 18. Choice	1. Here-and-Now a. Awareness (Internal and External) b. Coping skills c. Non-Verbal d. Unconventional 2. Decompression a. Relaxing b. Safe c. Enjoyable d. Calm e. Release 3. Relationship a. Connection b. Reciprocity c. Respect d. Trust e. Choice 4. Communication a. Non-Verbal	1. Here-and-Now Processing a. Awareness (Internal and External) b. Coping skills c. Decompression/Release d. Relaxing/Calm e. Enjoyable f. Safe g. Communication of needs h. Unconventional 2. Relational Connection a. Reciprocity b. Respect c. Trust d. Non-Verbal (Body Language) e. Choice

Observations. Reviewing the transcription of Monica, Joyce, and Aaron's observations, 17 codes were generated: selflessness, empathic reflection, concern, connection, reciprocity, relationship, here-and-now, congruence, trust, vulnerability, awareness (internal and external), decompression, release, leadership, communication, non-verbal (body language), and choice. From these 17 codes, 4 categories developed: here-and-now, connection, congruence, and communication. Finally, from these 4 categories, two themes emerged: here-and-now processing and relationship/connection. See Table 6 for the breakdown.

Table 6

Codes/Nodes, Categories, and Themes for Participant Observations

Codes/Nodes	Categories	Themes
1. Selflessness 2. Empathic reflection 3. Concern 4. Connection 5. Reciprocity 6. Relationship 7. Here-and-now 8. Congruence 9. Trust 10. Vulnerability 11. Awareness (Internal and External) 12. Decompression 13. Release 14. Leadership 15. Communication 16. Non-Verbal (Body Language) 17. Choice	1. Here-and-Now a. Awareness b. Decompression c. Release d. Selflessness 2. Connection a. Choice b. Relationship c. Concern d. Reciprocity 3. Congruence a. Trust b. Vulnerability c. Empathic reflection 4. Communication a. Leadership b. Non-Verbal (Body Language)	1. Here-and-Now Processing a. Awareness (Internal and External) b. Decompression/Release c. Congruence d. Empathic reflection e. Selflessness f. Communication 2. Relationship/Connection a. Choice b. Reciprocity c. Concern d. Trust e. Vulnerability f. Non-Verbal (Body Language)

Photo-Interview. Reviewing the transcription of Monica, Joyce, and Aaron's photo-interviews, 19 codes were generated: non-verbal, body language, protection, reciprocity, choice, relationship, connection, strength development (coping skills), selflessness, awareness (internal and external), peace, calm, tranquil, decompression, here-and-now, grounding, communication, respect, and trust. From these 19 codes, 3 categories developed: communication, here-and-now, and relationship. Finally, from these 3 categories, two themes emerged: here-and-now processing and relationship/connection. See Table 7 for the breakdown.

Table 7

Codes/Nodes, Categories, and Themes for Participant Photo-Interviews

Codes/Nodes	**Categories**	**Themes**
1. Non-verbal 2. Body language 3. Protection 4. Reciprocity 5. Choice 6. Relationship 7. Connection 8. Strength development (Coping Skills) 9. Selflessness 10. Awareness (Internal and External) 11. Peace 12. Calm 13. Tranquil 14. Decompression 15. Here-and-now 16. Grounding 17. Communication 18. Respect 19. Trust	1. Communication a. Non-verbal 2. Here-and-now a. Body language b. Strength development (Coping Skills) c. Awareness (Internal and External) d. Grounding e. Peace/Calm/Tranquil f. Decompression 3. Relationship a. Protection b. Reciprocity c. Choice d. Connection e. Selflessness f. Respect g. Trust.	1. Here-and-now a. Body language b. Strength development (Coping Skills) c. Awareness (Internal and External) d. Grounding e. Peace/Calm/Tranquil f. Decompression 2. Relationship/Connection a. Protection b. Reciprocity c. Choice d. Selflessness e. Respect f. Trust g. Communication h. Non-Verbal

Researchers Interpretation of Photograph. The last point of data collection was my own personal reflection and interpretation of the participants photograph. Reviewing Monica, Joyce, and Aaron’s photograph, 9 codes were generated: trust, here-and-now, relationship, connection, non-verbal, communication, awareness, peace, and decompression. From these 9 codes, 3 categories developed: here-and-now, relationship, and decompression. Finally, from these 3 categories, two themes emerged: here-and-now processing and relationship/connection. See Table 8 for the breakdown.

Table 8

Codes/Nodes, Categories, and Themes for Researchers Interpretation of Photograph

Codes/Nodes	Categories	Themes
1. Trust 2. Here-and-now 3. Relationship 4. Connection 5. Non-verbal 6. Communication 7. Awareness 8. Peace 9. Decompression	1. Here-and-now a. Awareness b. Non-verbal 2. Relationship a. Connection b. Trust c. Communication 3. Decompression a. Peace	1. Here-and-Now Processing a. Awareness b. Non-Verbal c. Decompression d. Peace 2. Relationship/Connection a. Trust b. Communication

Cross-Case Synthesis

As previously stated in Chapter 2, Roger's client-centered approach espouses several important assumptions. First, is the client's own unique subjective experience (Kensit, 2000). The Rogerian perspective understands the client experience as uniquely his or her own. Therefore, no other individual has the ability and/or right to insert him or herself into the experience. The second assumption of the client-centered approach is the individual's desire toward self-actualization. According to Bozarth (1997), self-actualization is the journey toward the internal status of autonomy.

These two basic assumptions unlock several concepts unique to the client-centered approach and this subsequent study. First, it encourages clients to move toward independence (Lux, 2010; Tudor, 2010). Second, it requires the client to be present in the here-and-now moment rather than focusing on the past and/or future experiences. Third, the client-centered approach focuses on the importance of the therapeutic relationship. As stated throughout this study, the precepts of the client-centered framework informed all aspects of this collective exploratory case study.

In the following section below, I will discuss the two major themes and the subsequent subthemes that emerged from the aforementioned cross-case analysis within each data collection point. Each theme and sub-theme will be supported by participant statements, and triangulated with theory from the literature.

Theme One: Here-and-Now Processing

Each participant expressed uniqueness of the here-and-now processing of EFP in comparison to traditional therapeutic approaches. On several different occasions Monica stated that she felt that she was able to progress through therapy on her own terms and did not feel forced to go the prescribed direction of the therapist. Aaron stated, “It is unconventional. I like that it is outside, and that you are working with animals. The only thing I know when I am getting ready for the appointment is that I am going to work with a horse. You never know what is going to happen that day, you never know how the interaction with the horse will go.” Reflecting on her here-and-now experience, Joyce stated, “I just like to hang with the horse, do light grooming, and let the horse be close to me. Just being able to be close to the horse is very cathartic to me when I have a problem.”

Awareness experiences. The need for internal and external awareness appeared to be very important when working with the horse. Participants had to be keenly aware of his or her internal processes as well as the external processes of their horse. The idea of congruence was a key component to each participant’s awareness experiences. Joyce reflected that she was drawn to the horse because she was afraid of the horse. This realization allowed Joyce to be keenly aware of her internal processes (e.g. breathing, heart-rate, etc.) so that she could safely and effectively engage with her horse (Oliver). Similarly, Aaron mentioned his respect for the horse, “at any time they could just trample you if they wanted to, having that knowledge make the

respect present when interacting with the horse." Aaron later explained that he had to stay grounded in the present moment of the session, work on his triggers, and reflect on how his anxiety/PTSD could have affected his horse (Jake). Monica differed from the other two participants inasmuch as she would constantly talk with Vickie (horse), enhancing Monica's internal and external congruence, thus enriching the therapeutic relationship. Joyce also recognized the importance of congruence when she stated, "In the real world I can put a mask on. I've been through therapy for years and never talked about my issues until this past year. This has been such a different experience, even in my first session. You have to focus on your breathing and keep your heart rate low. I can be calm on the outside but a mess on the inside, and this does not work with the horse."

Non-Verbal experiences. The non-verbal experiences of each participant appeared to be tantamount to their therapeutic progress. All three participants were asked by his or her therapist to watch the horse's body language and reflect on what it could be communicating. Several times early on in her session, Joyce was asked to consider what message she was sending to Oliver (horse) by having her hands in her pocket. Even though Joyce stated her hands were cold, and that's why her hands were in her pocket, it was very interesting to watch how Oliver responded once her hands were out in the open. Monica presented as the most experience of the three participants, and would make assertions as to Vickie's non-verbal responses to both external stimuli (e.g. distractions in the barn) and internal and/or relational stimuli (e.g. picking up on cues from her interaction with Monica). Aaron seemed to struggle with connecting Jake's (horse) body language cues to certain situations within the therapeutic space. This seemed to be indicative to his own lack of internal awareness and how his own non-verbal cues were affecting Jack.

Decompression experiences. The unconventional experiential nature of EFP required each participant to intently focus on his or her own physio-emotional status in relation to the horse. The decompression experiences appeared to be two-fold. First, numerous times throughout each session the therapist would ask the participant to take a deep cleansing breath to release the built up tension. Almost immediately after the participant would take a breath, the horse would follow suite thus enhancing the decompression of the participant. Beyond the immediate here-and-now release of built up anxiety, anger, or tension, each participant describe their experience with the horse as one of peace, calm, and tranquility.

Grounding experiences. Grounding is an essential tool within the context of here-and-now processing (Brandt. 2013; Lentini & Knox, 2008). Grounding is very similar to mindfulness and requires the participant to remain in the present by connecting physically to the horse. Joyce reflected on the importance of grounding stating, “You don’t focus solely on yourself, you have to think about the horse, almost worry about the horse because the horse is so powerful that you have to be concentrating on them and how they are doing and how they are going to react to you. So, you have to keep yourself calm, you have to keep yourself in check.” Monica, Joyce, and Aaron were all asked, at different times throughout the session, to place their hands on the horse’s chest and torso. This exercise seemed to calm both the participant and the horse down, grounding them to the present moment. Aaron reflected on a grounding experience with the horse, stating, “Grounding techniques have given me a foundation to hold it together when I start to freak out. As a matter of fact, I did not tell my therapist this, but I had a pretty bad anxiety attack and I was able to think about to the connecting exercise with the horse where I was able to have my hands on the horse and breathe. I was able to focus on my breathing and that helped me get through it and ground me.” Similarly, Monica remembered, “I felt her and breathed for the

first time in a very long time. And once I did, I relaxed and she relaxed. The more she relaxed the more I relaxed. We helped each other. And it just was. And we did that for several weeks. And then the more I came, the easier it was just to be."

Theme Two: Relational Connection

The second major them developed from the cross-case analysis is tied very closely to the here-and-now processing. The importance of the relational connection between the horse and the participant appeared to be essential to the success of the therapeutic process. Monica's relationship with Vickie reflected that of a close intimate friend, whereas Joyce and Aaron were still getting to know their horses. Nevertheless, each case depicted the importance of learning to connect with the horse both physically (e.g. grounding techniques) and emotionally (e.g. development of awareness). The relational connection was then developed as trust and respect was reciprocated and as the capacity for active communication developed.

Trust experiences. The triangulation of trust appeared to be a very important component for therapeutic advancement. The participant had to develop trust with the therapist who then brokered trust between them and the horse. The crux of Monica's experience with Vickie (horse) was based on Vickie choosing Monica. As previously stated in Monica's within case analysis, Vickie was the one that chose to work with Monica. From that initial connection, Monica and Vickie appeared to enter into a reciprocal relationship of mutual beneficence and trust. All three participants appeared to develop a reciprocal relational processing with their respective horses. Aaron appeared to understand Jake's (horse) hypervigilance and as a result was able to empathically connect with Jake, without forcing himself on Jake. Their interactions almost took on dance like qualities as Jake would walk away from Aaron to explore a sound or a distraction. Aaron would allow Jake space, then go to him, invite him to engage by connecting with him by

placing his hands on his torso and chest. Aaron would then back away from Jake and reengage with the therapist. This provided Jake with the option to reengage the relationship, which he always did, thus building the necessary trust.

Joyce emerged as the least experienced participant. Though she constantly stated that her horsemanship skills were lacking, she seemed to understand the importance of connecting. Trust between Joyce and Oliver (horse) was built slowly as Joyce became more and more comfortable with Oliver. She initially just stood with Oliver until she was able to regulate her breathing, once her breathing was regulated, she pulled her hands out of her pockets and place her hands on Oliver's chest and torso. This act of connection allowed both Joyce and Oliver to relax together as evidenced by the collaborative deep breaths and body posture. As they relaxed together, the reciprocal trust appeared to strengthen.

Communication experiences. Communication presented as another key for therapeutic success. The veteran's communication experiences took two on two distinct forms. First, were the non-verbal experiences. These experiences were consistent throughout each of the participant's sessions. All three participants were consistently asked to reflect on the horses body language in relation to their surroundings, their interactions with their environment, and their interactions with the participant. Concurrently, each participant was asked to pause and reflect on his or her own non-verbal interactions in relation to their surroundings, their interactions with their environment and their interactions with the horse. This reciprocal experiencing allowed the participant time to pause, reflect on his or her communication, and adjust accordingly. This type of experiential processing happened throughout the observed sessions and was repeatedly referred to in the interview portion of this study.

The second type of communication experience was the intentional verbal communication between the horse, the participant, and the therapist. The therapist would notice something within the therapeutic context and would intentionally broach the subject with the participant. Aaron was asked to consider Jake's anxiety/hypervigilance and relate it back to his own experiences. Monica was asked to share with Vickie how she was feeling in the moment, thus allowing her to process through her anxiety, depression, and/or frustrations. Joyce, was asked to just talk to Oliver about her day, thus removing the potential awkwardness of Joyce's lack of horsemanship.

Evidence of Trustworthiness

Multiple measures were employed to ensure the trustworthiness of this collective exploratory case study. First, prior to data collection, the initial proposal underwent a rigorous dissertation committee and IRB review and approval. This process ensures that the theoretical foundation, research methodology, and main research questions were built upon a solid foundation. Once IRB standards were met and the initial oral defense was completed, the preliminary steps of the data collection could begin. Second, transferability was taken into consideration through the use of descriptive data collection procedures and specific protocols outlined in Appendices B, C, and D.

Third, necessary triangulation took place through two rounds of member checking. First, an email of each transcription (e.g. interview, observation, and photo-interview) was sent to the participant for member-checking. Participants were asked to review the transcribed data for accuracy and make changes where necessary. No changes were made. Second, each of the coded transcriptions was sent to the dissertation chair and methodologist for review. Through a series of collaborative exchanges, clarity was achieved, thus allowing for interrater reliability.

Credibility

Outlined in Chapter 3, I chose to use prolonged exposure/engagement and member checking to enhance the validity of this collective exploratory case study (Morrow, 2005; Stake, 2006; Yin, 2014). Prolonged exposure/engagement was used to enhance the credibility of the study. I was able to spend approximately 3.5 to 4 hours with each participant and as such was able to develop rich, thick descriptions of their experiences through the use of interviews, observations, and photo-interviews. Member checking (Stake, 2016; Yin, 2014) was also utilized through email exchanges of transcribed data. This allowed each participant to provide feedback on his or her experiences and approve the final transcription.

Transferability

To ensure transferability, three different participants in an EFP program were interviewed and observed to gain a diverse understanding of the lived experiences. Consistent data collection was utilized across cases as specific protocols were developed and utilized to ensure consistency (see Appendices B, C, & D). However, transferability is often left up to the reader (Marshall & Rossman, 2015). Transferability was achieved as there were common themes between the three veteran survivors with partial or full PTSD. Though there is limited and/or lacking data to confirm the overall efficacy of EFP with veteran survivors with partial or full PTSD, this study provides a framework for future research and could be replicated among similar demographics (i.e. other veterans across the country) with a high probability of similar themes developing. Furthermore, the basic design of this study could be replicated among non-veteran survivors with PTSD with a high probability of similar themes developing as well.

The field notes and research journal provided a platform for concurrent notes to be recorded during the process of data collection. The field notes and research journal broadened

the scope of the data analysis, thus enhancing the rich, thick descriptions of the collected data. The field notes and research journal enhanced the interviews and observations inasmuch as they captured the participant's body language and non-verbal communication. The research journal allowed me a place to write down my reflections of participant characteristics during the interviews (i.e. initial interview and photo interview). The research journal recorded the non-verbal responses of the participants (i.e. emotions, body language, etc.) as they discussed their experiences with EFP. The use of this journal along with the observation field notes enhanced the depth and richness of the collected content. It also confirmed the responses of the participants' as they were congruent with the emotions and body language displayed in the data collection. The contents of the research journal are interspersed throughout the data analysis section.

Dependability

Data triangulation and the use of an audit trail (e.g. a detailed chronological account) were used to achieve dependability. Data triangulation was achieved through brief conversations with the dissertation committee concerning data collection, analysis procedures, and application of the theoretical foundation (client-centered theory) to the results of the interviews, observations, and photo-interviews. The audit trail was completed through field notes and the research journal.

Confirmability

Confirmability deals with the amount of objectivity within the study (Morrow 2005). Though it is impossible to achieve 100% objectivity within a study, steps were taken to enhance the overall integrity of the study. Confirmability was achieved through the discussion of

researcher bias and a self-interview. Furthermore, confirmability was achieved by providing an audit trail through the use of the field notes and research journal.

Summary

The research question central to this study was: what are the experiences of veteran survivors with PTSD who utilize EFP for their recovery? The four sub-questions were (a) how do veteran survivors with PTSD describe their experiences with EFP? (b) does EFP benefit the recovery of veteran survivors with PTSD? (c) how do veteran survivors with PTSD describe the effects of EFP toward their recovery? and (d) what treatments have veteran survivors with PTSD experienced prior to EFP? The dada was analyzed using hand coding analysis through organizing, coding, and conceptual modeling.

Central Question: What are the experiences of veteran survivors with PTSD who utilize EFP for their recovery?

The data produced by the interviews, observations, and photo-interviews thoroughly answered the central question of this study in terms of the recovery experiences of veteran survivors engaged in an EFP program. All participants described learning how to be in the moment through here-and-now processing. They all described that by being encouraged to remain in the moment of the session, they learned how to be aware of their internal state in relation to their external circumstances. Each participant stated that they learned coping skills to reduce their anxiety. Monica and Joyce reported learning how to communicate their needs to both the horse and the therapist. Monica indicated that by being in EFP she was no longer experiencing paranoia or hypervigilance in her daily life. Aaron stated that EFP has helped him leave his home on a more regular basis without fear and hypervigilance. All three participants

reminisced on the strength of the developed intimate relationship with their horse and how that connection has helped them cope with their PTSD symptoms.

Sub-Questions

Sub-Question One: How do veteran survivors with PTSD describe their experiences with EFP?

In describing their experience with EFP, Joyce found herself drawn to the horse even though she was scared of it. All three participants described their time with the horse as enjoyable, safe, relaxing, and calming. Monica expressed her relationship with Vickie (horse) in more intimate terms (i.e. "she protects me" or "she loves me"), while Joyce and Aaron were still exploring the newness and nuances of the relationship.

Sub-Question Two: Does EFP benefit the recovery of veteran survivors with PTSD?

Each participant stated that EFP provided a foundation for their recovery inasmuch as they were able to learn coping skills, communication skills, awareness skills, and decompression skills. Furthermore, each participant described being able to translate the learned experiences to their day-to-day lives.

Sub-Question Three: How do veteran survivors with PTSD describe the effects of EFP toward their recovery?

In terms of describing the effects of EFP on their recovery, all three described an overall improvement in sense of general well-being. Monica indicated that her EFP experiences have helped her maintain a sense of calm, learn how to better interact with the world, and has enhanced her ability to be assertive. Joyce, expressed the ability for her to find peace and ways to decompress when faced with stress. Aaron revealed that his time in EFP has decreased his

hypervigilance, while helping his success in his other therapies. Aaron stated that all veterans should do EFP first as it would help significantly in the success of other therapies.

Sub-Question Four: What treatments have veteran survivors with PTSD experienced prior to EFP?

All three participants had been in prior therapy with Monica and Aaron receiving both individual and group counseling and psychiatric services concurrent with their EFP sessions. Monica indicated that she had tried PE, EMDR, psychotherapy groups, in patient therapy, and medication prior to EFP. Joyce stated that she has been in some sort of therapy for 25 years and has tried things like anger management, trauma therapy, five years of EMDR, art therapy, and Krav Mgra. Aaron stated that he had been in in-patient treatment for substance abuse, has tried EMDR, CPT, and various types of group therapy.

The data provided from the interviews, observations, and photo-interviews, with the participants and researchers interpretation of the photograph answered all of the research questions. The veteran survivors' rich experiences with EFP provided context into the unique therapeutic processes therein. Veteran survivors with partial or full PTSD were able to share their experiences with EFP and the innate benefits as a result of their interactions with the horse. The within-case analysis captured the rich, thick descriptions of each participant's unique interactions with the horse while the cross-case analysis recognized the two main themes of here-and-now processing and relational connection. In Chapter 5, I discuss the interpretation of the findings, the limitations, the recommendations for future studies, and the specific implications of this study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

I began this study by exploring the experiences of veteran survivors with partial or full PTSD who were enrolled in an EFP program. I explored the subjective lived experiences of the veteran in correlation to his or her unique interaction(s) with the equine. Through the use of multiple data collection points (i.e. interviews, observations, and photo interviews), I documented multiple experiences among three veteran survivors with partial or full PTSD. I focused on the personal lived experiences of veteran survivors with partial or full PTSD engaged in an EFP Program, as there was limited and/or lacking data as to the experienced outcomes of EFP with this population. The importance of this research is two-fold. First, the research adequately informs the professional counseling community about the unique effects of EFP and, second, it provides an effective experiential adjunct or alternative for veteran survivors with partial or full PTSD.

I conducted this dissertation using a qualitative collective exploratory case study design. The collective exploratory case study design was the best choice to use in this study with lack of evidenced-based research and the limited number of potential participants (Creswell, 2013; Stake, 2006; Yin, 2014). The key phenomenon that I explored in this study was the lived experiences of veteran survivors with partial or full PTSD involved in an EFP program and its effects on their recovery.

I divided the key findings of this study into two themes: here-and-now experiences and the relational connection. These two themes naturally emerged from the data during the coding, categorizing, and thematic analysis of the interview, observation, and photo-interview data from

all three participants and enhanced the current EFP literature. Within these themes, the primary findings were the following:

1. Awareness experiences.
2. Non-verbal experiences.
3. Decompression experiences.
4. Grounding experiences.
5. Trust experiences.
6. Communication experiences.

The findings of this study provided, expanded, and enhanced the understanding of EFP and the unique experiences of those participating. I discuss the findings in more detail in the interpretation section.

Interpretation of Findings

In this section, I addressed two parts of interpretation of the data. First, I will discuss the impact in relation to the existing professional literature as a result of this study and I will discuss the extent to which the findings confirm, disconfirm, or extend the knowledge base of EFP literature compared to the literature review data in Chapter 2. Second, I will analyze and interpret the findings in the context of the theoretical framework presented in Chapter 2. The interpretations were organized by key findings listed in the introduction to Chapter 5. The experiences of three veteran survivors with partial or full PTSD engaged in an EFP program provided a glimpse into the struggles of partial or full PTSD and the experiences of EFP.

Impact on Current Literature

EAA/T is an adjunct modality within the AAT model. EAA/T is an umbrella terminology that encompasses HPOT, therapeutic riding, EAL, and EFP. As stated in Chapter 2, each form of

therapeutic interaction with in the EAA/T framework views the engagement with the horse as the construct for therapeutic success (Lentini & Knox, 2008; Selby & Smith-Osborne, 2013). The horse becomes a live bio-feedback machine whereby the reciprocal nature of the client-horse interaction is mirrored or reflected back in the present moment (Johansen et al., 2014). This basic client-horse concept was confirmed in this dissertation as all three participants were asked to remain present in the here-and-now moment of the session and work with the horse towards a positive outcome. Sometimes this would not happen instantaneously but over the course of the session. In the case of Joyce, the horse reacted/reflected early on in the session that he was unsure of something. It was not until later in the session that Joyce was able to be congruent with herself and disclosed her issues at home prior to the session and her current migraine. Once she was able to disclose those struggles, the horse was able and willing to connect.

EAA/T also posits that the non-verbal communication between client and horse is tantamount to the success of the therapeutic exchange. This presented true in all three participant horse interactions. Each participant was asked to reflect on the horses body language (i.e. ear position, movement, head position, etc.) and interpret the underlying theme. Joyce and Aaron had a difficult time with this task, but were told that it is a work in progress and that they would grow in competence as the sessions progressed. Monica, due to her previous horse interactions, was able to accurately surmise the horse’s non-verbal communication accurately and respond accordingly. All three participants were asked to consistently monitor their non-verbal communication in relation to the horse, and with the help of their therapist adjust accordingly. The following section will include an exploration of the main themes and sub-themes of this research in relation to the existing literature.

Theme One: Here-and-now Experiences. Brandt (2013), Johansen et al. (2014), Lentini and Knox (2008), Selby and Smith-Osborne (2013), and Porter-Wenzlaff (2007) all indicated that in order for the therapeutic equine interaction to be successful the client has to be properly grounded to the present moment of the session. This requires the client to put aside past stress/trauma or future worries, so as to be rooted in the here-and-now of the session. According to Lentini and Knox (2008), it is in the present tense, here-and-now process of the session that change happens.

This study confirms the limited research and enhances the depth of current research. The major theme of the here-and-now processing was extended to experiences of awareness (both internal and external), non-verbal communication, decompression, and grounding. Each sub-theme within the theme of here-and-now experiences will be briefly discussed in terms of how it confirms and extends the current research. Until recently, the components of here-and-now processing were assumed. This study was able to bring more definition to the specific concepts therein, including the importance of in the moment awareness of self (and self in relation to others), body language (non-verbal communication), and grounding experiences (including decompression).

Awareness Experiences. Within the collected data set, awareness appears to be an important component of the here-and-now experiences in relation to the participant-horse interaction. All three participants were challenged to reflect on his or her own internal status, that is, they were asked to be constantly aware of their feelings in relation to the horse, in relation to their surroundings, in relation to their therapist, and in relation to themselves. This concept is highly important to the therapeutic process inasmuch as the participant-horse interaction cannot fully commensurate unless the participant is fully congruent both internally and externally. Once

the honest congruence is developed, the horse is put at ease and is able to fully engage in the therapeutic process. However, it must be noted that this is a continuous exchange whereby the participant needs to monitor his or her internal status and make adjustments were necessary. Numerous times all three participants were asked to take as step back from the horse and reflect on their present internal cues. Joyce and Aaron had to be reminded, as novice EFP participants to reflect on their internal status, whereas Monica was able to respond on her own. Therefore, it appears that the development of internal awareness is a continuous process within the therapeutic journey.

Similarly, external awareness presented as an important concept within the success of the here-and-now experiences. The therapist (different with all three participants) consistently asked them to reflect on the position of the horse (i.e. what or how they were communicating in the moment). This concept ties together nicely with the non-verbal experiences, later discussed, as all three were asked to be aware of the horse in relation to the environment and in relation to themselves. This therapeutic exchange between participant and therapist is an exercise in the development of non-verbal/body language experiences. It allows the participant the opportunity to explore the effect of his or her engagement with the horse (i.e. is it positive or negative, and what are the physical cues to back up the assertion). I observed that when the participant is able to recognize the communication in the horse then he or she can make the necessary adjustments to accommodate the relationship. Furthermore, this is a practical tool that can be transposed onto the participant's everyday relationships as they can be asked to reflect on how their actions potentially affect others in their lives. Essentially providing the participant with a scenario in the here-and-now that can be applied life.

Nonverbal Experiences. This sub-theme confirms the assertions of Brandt (2013), Johansen et al. (2014), and Porter-Wenzlaff (2007) who stated that since horses rely heavily on nonverbal communication, the client must too be aware of his or her own nonverbal experiences. It is in this non-verbal exchange that the congruence of the client is supremely important. Combined with the concept of awareness, Aaron indicated that “a lot of that non-verbal work is sometimes more impactful than the words you can say.” He went on to say that “the connection you build with them is a nonverbal agreement for trust and for respecting boundaries.” Joyce was challenged to reflect on how her nonverbal incongruence was affecting her horse and what he was telling her by his nonverbal responses. Joyce was able to come into full congruence with herself and was able to see the immediate response of Oliver (horse). Monica described the non-verbal interaction as a way to tell how she was affecting her horse and how her horse was affecting her, “it’s like a barometer.” Again, these participant-horse experiences allow the participant the opportunity to experiment with real-life scenarios in a safe therapeutic environment. The hope is that once they are experienced in the safe therapeutic environment, they can be translated into the participant’s everyday life.

Decompression Experiences. This sub-theme confirms the research conducted by Marcus et al. (2013) who discovered that AAT reduces pain levels, stress and aggravation levels, and sadness levels, while significantly increasing levels of calmness, pleasantness, and cheerfulness. All three participants described their experience with the horse as one that calms them. All three participants stated that their horse helped them regulate their breathing, lower their state of anxiety, and produced an overall sense of peace. Similarly all three visually demonstrated calmness as the session progressed. On numerous occasions, Joyce likened her equine facilitated experience to yoga and stated several times that “it decompresses me.” Furthermore, Joyce’s

photograph depicted a serene scene of peace and calmness. Monica reflected by saying, "I am more peaceful, I am more calm, I am more than elated, I have not found a word that can describe it." Aaron stated, "the fact that it is outside relaxes me." All three participants demonstrated this concept of decompression as evidenced by the need to take multiple deep cleansing breaths throughout the session. As they would breathe, the horse would breathe, and a reciprocal decompression would happen.

Grounding Experiences. This sub-theme is very closely related to its parent theme of here-and-now experiences, but was worth teasing out due to the clarity it provided. Moreover, this sub-theme could easily be a component of the decompression experiences as well, as they tie nicely together. Nevertheless, what makes this idea of grounding experiences unique is the client's ability to translate the task(s) within the session to his or her daily life. Aaron stated that the time he spent physically connecting and grounding with the horse through deep breathing, helped him avert a panic attack between sessions. Monica indicated that she no longer experiences fear and hypervigilance as a result of her time with Vickie (horse). Joyce realized her tendency to put on a mask in the real world, and how her time with Oliver (horse) gave her the opportunity to ground herself in her true identity. This is significant to the therapeutic process inasmuch as the interaction with the horse cannot be fake or falsified. If the participant is going to genuinely work with the horse the barriers, such as Joyce's mask, must be removed. Therefore, the act of removing the barrier within the participant-horse interaction is where true therapy happens. As the participant moves towards his or her true self, they are able to see the horses demeanor change as it begins to connect with the participant.

The multiplistic components of the here-and-now experiences are key to the overall success of the therapeutic interaction between horse and client. Though there are similarities

between each component all four components work independently from each other to develop the basis for the therapeutic exchange. This is demonstrated in Figure 2 below.

Figure 5: Here-and-Now Experiences

Theme Two: Relational Connection. EAA/T espouses that the connection with the horse is essential to the overall therapeutic success (Granados & Agis, 2011; Bass et al., 2009; Cuypers et al., 2011; Frewin & Gardiner, 2005; Snider et al., 2007). This concept was confirmed in this dissertation as all three participants worked throughout the session to connect with their horse. It appeared that the entirety of the session was geared towards this relational connection. Two specific sub-themes of trust experiences and communication experiences developed from this parent theme.

Trust Experiences. Trust is a key component to the development of any relationship. Without trust, the relationship has a difficult time forming (Frewin & Gardiner, 2005). The need for trust and the development of trust appeared to be significant in the development of the client-horse relational connection. Due to the trauma experienced by each participant, they were

skeptical of the therapeutic process in general. All three struggled with inter-personal relational trust as evidenced by their failed relationships. Similarly, all three were still experiencing symptoms of hypervigilance from their partial or full PTSD, which hindered the development of trust. Joyce stated, that, "you don't focus solely on yourself…you almost need to worry about the horse because the horse is so powerful that you have to be concentrating on them and how they are doing and how they are going to react to you." She later stated that she was drawn to the horse because she was afraid of the horse, and this is where trust is developed. Aaron stated, "it is a trust thing. Trust comes hard for me as it comes hard for a lot of veterans…unless you've experienced some of the same things, you don't easily get trust." Aaron went on to say it is different with animals because trust is pretty cut and dry, "if I do this and interact in this way, I will gain trust with the horse and they with me." Furthermore, Aaron indicated that trust was the basis for the relationship between he and Jake (horse).

Communication Experiences. The reciprocal nature of the communication experiences enhanced the depth of relational connection. These communication experiences encompassed both verbal and non-verbal expressions as well as between client and horse, client and therapist, and within client. This reciprocal communicative exchange appeared to become the foundation from whence the therapeutic success developed. Each participant described their struggle to communicate well prior to coming to EFP. It was not until they were faced with the in the moment, here-and-now interventions with their horse that they began to learn how to properly communicate. The skills developed through this process included assertiveness skills, verbalizing needs, expressing feelings and emotions, and learning how to adjust to the needs of another (horse). Monica reported that Vickie (horse) was the one that taught her how to communicate with the outside world. Joyce was able to learn how her body language communication affected

her horse, and how a slight change in posture invited the horse into a closer connection. Aaron was able to learn how to read body language communication from his horse and he was able to respond accordingly. All three participants indicated that their interactions with the horse aided in the enhancement of their communication with the world.

The importance of the relational connection between client and horse also extends to the therapist. This provides a reciprocal triadic exchange that makes up the therapeutic relationship within EFP. The reciprocal relational connection with the horse, the therapist and the client is demonstrated in Figure 3.

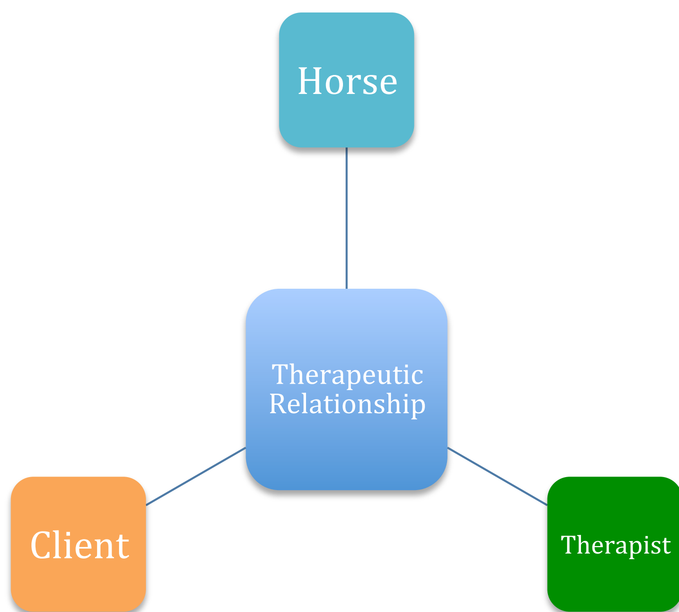


Figure 6: Therapeutic Relationship

Theoretical Framework: Client-Centered Theory

Client-centered theory, also known as the Rogerian model is a non-judgmental, non-invasive approach to therapy that places the crux of therapeutic change on the therapeutic

relationship (Kensit, 2000). Due to the limited and/or lacking data on EFP, the client-centered theory was adopted as a lens through which this study was viewed.

The client-centered approach asserts that the client's phenomenology and/or subjective experience is highly valued inasmuch as the client's experience is unique and no one else has the ability to fully understand his or her reality. Furthermore, the client-centered approach posits that the client has the innate desire and drive to move from heteronomy to autonomy, thus achieving self-actualization (Bozarth, 1997; Kensit, 2000). This study sought to understand the unique experiences of each client without being inserted into the experience itself. All three participants were able to tell their story through both verbal and non-verbal communication. Similarly, it was interesting to watch as each participant desired autonomy within the triadic therapeutic relationship (see Figure 3). Monica talked about the session where Vickie (horse) no longer had to breathe for her, instead, Monica had achieved the confidence needed to become successful on her own. From that moment on, Monica reported that she was able to take care of Vickie, instead of needing to be cared for by Vickie. Joyce and Aaron appeared to be still on that journey toward autonomy as they relied heavily on the horse for cues, feedback, and support.

It is from these assumptions that develop the Rogerian model for therapy. The client-centered approach uses congruence, empathy, and unconditional positive regard as its basic therapeutic framework (Lux, 2010). Congruence is the process whereby an individual is open to his or her experience and is able to integrate both the internal and external representations therein (Lux, 2010). This concept was seen throughout the entirety of the Equine Facilitated Psychotherapeutic sessions. All three participants had to consistently reconcile his or her internal status with the external here-and-now processing of the session. Joyce was the biggest example of this playing out as she had the most hidden internally. From the start of her session, Joyce had

her hands in her pockets, which put Oliver (horse) on edge. Even when she removed her hands from her pockets, Oliver was still skeptical. It was only when Joyce made her internal state known and therefore congruent with her external state that she was able to connect with Oliver. Monica and Aaron displayed this similarly in their external deep breaths. By exhaling deeply both Monica and Aaron were able to expel the internal anxiety and tell their horse what was going on inside. Often, the horse would respond by taking a deep cleansing breath too.

In addition to congruence, the Rogerian understanding of empathy is key to the success and/or failure of the therapeutic relationship (Bozarth, 1997). This also holds true within EFP. Empathy within EFP is a reciprocal exchange where the client is aware of the horses feelings, stresses, or anxieties and on a lesser sense, the horse is concerned for the client. Empathy was woven throughout the fabric of this study even though all three participants experienced it in different ways. Monica shared that during her initial sessions she felt as if she was forcing herself on Vickie (horse). Instead of continuing with the exercise, she spoke up and asked the therapist if they could simply connect. During Aaron's session, his horse Jake was periodically agitated with his surroundings. Aaron was asked to speculate on what was bothering Jake and then was asked what he thought the proper response should be. Conjointly, Aaron was then asked to reconnect with Jake on terms that were beneficial for both. Though Joyce was still learning, she was still able to pick-up on what was bothering Oliver (i.e. being away from the herd, hungry, and anxious about the wind), and was able to empathically respond to his needs. Empathy is also a key component for the therapist to utilize within the Rogerian approach, as he or she is the one who often translates the interactions between the horse and the client during the initial sessions. It appeared that the greater the empathic understanding of the therapist, the greater the empathic exchange between the client and the horse. This is significant, as it appeared

to help the veteran survivor connect with the needs/experiences of another (horse), thus taking the focus off of his or her symptomology. This enhanced the participant's ability to look outside of themselves to understand how they can affect those around them, increasing the relational awareness.

The final component of client-centered theory is what Rogers called unconditional positive regard. This is where the therapist accepts the totality of the client's feelings, emotions, cognitions, and experiences without judgment (Bozarth, 1997). According to Lux (2010), unconditional positive regard is characterized by compassion, warmth, acceptance, non-judgment, respect, and admiration. In this study, unconditional positive regard was seen between the therapist and the client and between the horse and the client. The unconditional positive exchange happened when each participant was able to become fully congruent. Monica stated, "this is the only place that I have not been judged. Animals don't judge, the people that work with the animals don't judge." Joyce stated, "he is very kind to me and shows me some affection." Similarly Aaron stated, "I think there should be a certain amount of time for both of us to have space from each other as well as working with each other, which helps build the relationship and trust, which makes the therapy more effective." Aaron's, comment ties together the understanding of the participant-horse interaction as a microcosm for therapeutic processing. Within the triadic therapeutic relationship, the participant is able to experiment with communication strategies, boundaries, assertiveness skills, trust development, etc. in the context of a safe welcoming environment. When success is achieved in the therapeutic relationship, the participant is then empowered to utilize the learned skills in his or her real life.

Overall, the theoretical framework of client-centered theory integrated well with the data. First, the client-centered approach pairs well with EFP as it does not manage or direct the

session, but rather allows the client to focus on the here-and-now experiencing of his or her feelings, emotions, and cognitions. Second, there is intentional emphasis on the triadic therapeutic relationship (see Figure 3) as a conduit for congruence, empathy, and unconditional positive regard to flourish.

Limitations of Study

The limitations of this study are similar to that of other case study designs. This manifested in a small number of participants, the limitations of qualitative data for generalizability, and the limitations of data analysis (Stake, 2006; Yin, 2014). The limitations specific to this study are discussed in the following section.

One limitation was the difficulty in recruiting participants. This was due to several factors. First was the lack of therapeutic ranches actually providing PATH International certified EFP. After an exhaustive search, three certified ranches agreed to participate with participants from only one ranch agreeing to the process. Second, was the difficulty in finding participants who could commit to the sessions. Several participants struggled to make their session due to funding issues with the Wounded Warrior Project. Once the funding issues were resolved the participants were able to return and the research was able to happen. Finally, was the access to EFP. Though the benefits of EFP are known, access for veterans is limited as evidenced based practices are preferred.

Second, was understanding the etiology of the participants PTSD. Though each participant indicated a diagnosis of PTSD, it was difficult determining the origin of the trauma. The Trauma Screening Questionnaire (TSQ) did an adequate job of assessing current symptomology, but a more extensive PTSD screening and/or developing stricter inclusion criteria would be beneficial. By expanding the scope of PTSD history/etiology it would allow the

researcher the ability to limit the study to combat PTSD versus complicated PTSD from numerous sources prior to enlistment or deployment..

Third, the unorganized nature of EFP itself made it difficult to find standardized outcomes. Though there were similarities among each participant in each session, the therapist did not follow a common script. This also hurt the participant recruitment procedures as many ranches stated they were doing EFP when in all actuality they were practicing something else.

Fourth, there proved to be a slight limitation with the data analysis. With the limited and/or lacking data surrounding EFP and EFP with adults (specifically veterans), there were inadequate themes in the literature from which to develop codes. Subsequently, the coding allowed each piece of the collected data to speak for itself with themes developing from each case. The themes that developed from each collected data point confirmed and enhanced the themes in the literature among the child and adolescent populations (Cuypers, Derider, & Strandheim, 2011; Kern et al., 2011; Memishevikj & Hodzhikj, 2010).

The final limitation has to do with the possible geographical barriers in accessing this therapeutic modality. Many survivors with full or partial PTSD are city dwellers and do not have direct access to a farm or a ranch whereby they could partake in this alternative therapy. Furthermore, the cost of this therapy could also be a potential barrier.

Recommendations

Based on the limitations and the general lack of data on EFP, several recommendations for future/further research arise. First, a qualitative phenomenological study of several different ranches would potentially enhance the generalizability of the effects of EFP to those participating in therapy. Second, a longitudinal experimental study of active duty participants could possibly show the efficacy of the equine-human bond and the impact it could have on

those preparing to deploy and/or those returning from deployment. Third, a longitudinal study could track pre and post deployment PTSD symptoms and the potential Posttraumatic Growth strategies provided by EFP. Furthermore, a longitudinal study could look at the sustained (or lack thereof) effects of EFP in relation to other evidenced based therapies. It would behoove future research to look at the recidivism of PTSD symptomology in correlation to EFP and determine whether or not it mirrors the aforementioned symptom severity within veterans survivors as outlined by Lefkowitz et al., (2005); and Sharpless and Barber, (2011).

There would also be significant value in repeating this currents study in other geographical regions of the United States where there is a concentration of military and veterans. Additionally, it could be useful to partner with similar researchers in other countries to provide a culturally diverse understanding of the equine-human bond. This would enhance the efficacy of this current study along with the commonalities of Equine Facilitated programs across the globe, thus increasing the possibility of a future quantitative study.

Furthermore, it might be beneficial for Equine Facilitated Psychotherapists and/or governing agencies to develop a grounded theory project. By developing a grounded theory research project, a standardization of EFP could be established thus enhancing its efficacy and promoting third party insurance reimbursement. With third party insurance reimbursement more individuals would have access to it.

Lastly, there would be value in developing a study to explore the Equine Facilitated Experiences of officers within the military. The current study was only able to focus on enlisted individuals, which often present different treatment issues than officers. By studying the effects of EFP on officers, a broader understanding of its effects on PTSD could be ascertained.

Implications for Positive Social Change

As stated in Chapters 1, 2, and 3, there is a lack of PTSD treatment diversity and limited or lacking research on EFP with the veteran population. The purpose of this study was to explore the experiences of veteran survivors with partial or full PTSD involved in an EFP program. The findings of this study provide a necessary step in the groundwork for positive social change in the area of alternative and/or adjunct therapy options for veteran survivors with partial or full PTSD. This study added to the academic knowledge of EFP as well as broadening the understanding of the unique experiences of veteran survivors with partial or full PTSD.

This study shed light on the difficulty veteran survivors with partial or full PTSD face in finding an efficacious therapy. Though there are good evidenced based therapies available to veterans, it appears veterans struggle to maintain positive therapeutic growth as evidenced by the failed therapeutic experiences of the veteran participants. Each participant openly shared his or her previous therapeutic experience in relation to EFP. This study shows that there is a powerful impact between the interaction of the participant and the horse towards growth and healing. EFP has the potential to be a powerful experiential adjunct to the aforementioned evidenced based therapies for veterans. Aaron emphatically stated in his interview

> “There is really no comparison to other therapies. I would recommend it to veterans. The more severe their PTSD is, the more progress they would make in this therapy. Instead of being reactive therapy or a last resort, this should be a therapy that they go to first…because if I had something like this in the beginning, then going to some of the other therapies would have not been so bad because when those things came up I would have had a foundation where I could better cope and tools that I could draw from.” “There is really no comparison to other therapies. I would recommend it to

> veterans. The more severe their PTSD is, the more progress they would make in this therapy. Instead of being reactive therapy or a last resort, this should be a therapy that they go to first…because if I had something like this in the beginning, then going to some of the other therapies would have not been so bad because when those things came up I would have had a foundation where I could better cope and tools that I could draw from."

Every veteran survivor with PTSD should be given the opportunity to experience the healing power of the horse.

There was also a benefit to the mental health profession as a whole. This study provided rich, thick descriptions of the impact of EFP on veteran survivors with partial or full PTSD. This provides counselors and counselor educators with the opportunity to make an informed decision with an alternative therapy to utilize. Similarly, with a new generation of veteran survivors with partial or full PTSD reengaging society, this study provides a viable alternative to traditional therapies such as talk therapy, CPT, and EMDR, PE

Conclusions

With this study, I conveyed the unique experiences of veteran survivors with partial or full PTSD involved in an EFP program, through a collective exploratory case study design. The plight of our men and women in uniform is a complicated one as many experience multiple deployments within a short amount of time. Since September 11, 2001, the intensity of these deployments has also increased, thus increasing the potential for mental health issues such as anxiety, depression, and PTSD.

This study explored an alternative therapeutic modality that could be sued to treat this new generation of veteran survivors with partial or full PTSD. Through the use of interviews,

observations, and photo-interviews, rich, thick descriptions of the veteran survivors experiences were collected. Two key themes of here-and-now experiences and relational connection told the story of the distinctive participant experiences. Each veteran survivor participant experienced the uniqueness of EFP and the subsequent benefits therein. One participant openly suggested, “I would recommend it to veterans. The more severe their PTSD is, the more progress they would make in this therapy. Instead of being a reactive or last resort, this therapy should be first. If I had something like this in the beginning, then going to some of the other therapies would have not been so bad because when the trauma came up I would have a foundation were I could better cope.”

The purpose of this study was to explore the lived experiences of veteran survivors with partial or full PTSD involved in an EFP program. The results of the study confirm and enhance the existing literature and provide a detailed understanding of the veteran survivors exceptional experiences. The veteran survivor participants not only shared their experiences with EFP, they also provided a glimpse into the struggle of PTSD. Through their stories, counselors and counselor educators have the opportunity to be better informed in the treatment of veteran survivors with partial or full PTSD. Furthermore, the first bricks of the foundation were laid in exploring the efficacy and viability of EFP as an experiential alternative to traditional therapy.

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Appendix A: Demographic Questionnaire

1. Gender:

   ☐ Male ☐ Female

2. Age: ______

3. Race/Ethnicity:

   ☐ African American
   ☐ Hispanic
   ☐ Asian/Pacific Islander
   ☐ Caucasian/White
   ☐ Other (please specify): __________________

4. Marital or relationship status:

   ☐ Single
   ☐ Living together in a committed relationship (not married)
   ☐ Married
   ☐ Separated
   ☐ Divorced (not remarried)
   ☐ Widowed (not remarried)

5. Service members present (or highest) pay grade:

   ☐ E1-E4
   ☐ E5-E9
   ☐ W1-W5
   ☐ O1-O3
   ☐ O4 or above
   ☐ Do not know

6. What is your highest level of education?

   ☐ Grade School
   ☐ Some high school
   ☐ High school grad (or GED)

- ☐ Trade/vocational school
- ☐ Some college
- ☐ Completed community college
- ☐ Four year college
- ☐ Graduate school

7. Military service branch: ____

8. Number of deployments: ______

9. Do you have a formal diagnosis of PTSD: □ ***Yes*** □ ***NO***

   If **Yes** when did you receive the diagnosis? _________________________

10. Are you currently receiving treatment?
    - ☐ Counseling
    - ☐ Psychiatry
    - ☐ Other (explain): _________________________

11. Please answer as honestly as possible:

    Do you smoke?
    Tobacco: YES NO
    Marijuana: YES NO
    Do you use drugs? YES NO Drug(s) of choice? _________________________
    Do you drink alcohol? YES NO How many drinks per week? _________________

12. How did you find out about the EFP Program?

13. How long have you been attending the EFP Program?

Appendix B: Trauma Screening Questionnaire

Trauma Screening Questionnaire

(Public Domain)

Please consider the following reactions which sometimes occur after a traumatic event. This questionnaire is concerned with your personal reactions to the traumatic event which happened to you. Please indicate (Yes/No) whether or not you have experienced any of the following at least twice in the past week.

1. Upsetting thoughts or memories about the event that have come into your mind against your will.
   □ ***Yes*** □ ***NO***
2. Upsetting dreams about the event.
   □ ***Yes*** □ ***NO***
3. Acting or feeling as though the event were happening again.
   □ ***Yes*** □ ***NO***
4. Feeling upset by reminders of the event.
   □ ***Yes*** □ ***NO***
5. Bodily reactions (such as fast heartbeat, stomach churning, sweatiness, dizziness) when reminded of the event.
   □ ***Yes*** □ ***NO***
6. Difficulty falling or staying asleep.
   □ ***Yes*** □ ***NO***
7. Irritability or outbursts of anger.
   □ ***Yes*** □ ***NO***
8. Difficulty concentrating.
   □ ***Yes*** □ ***NO***
9. Heightened awareness of potential dangers to yourself and others.
   □ ***Yes*** □ ***NO***
10. Being jumpy or being startled at something unexpected.
    □ ***Yes*** □ ***NO***

If you have answered yes to 6 or more questions you are encouraged to consider whether you think that some counseling support may be of benefit in helping you to lower your on-going reactions to the traumatic event.

Source: Brewin, C. R., Rose, S., Andrews, B., Green, J., Tata, P., McEvedy, C., Turner, S. & Foa, E. B. (2002) Brief screening instrument for post-traumatic stress disorder. *British Journal of Psychiatry, 181*, 158-162.

Appendix C: Interview Protocol

This interview protocol will be used in the face-to-face semi-structured interviews. Due to the nature of the qualitative case study design the following questions will not be the only questions asked during the semi-structured interview; however each of the following questions will be asked to each of the participants during the semi-structured interview process. Each of the questions are open-ended and intend to answer the research questions in this study concerning veteran survivors with posttraumatic stress disorder participating in an EFP program.

1. What has been your experience with EFP?
2. How has EFP impacted your life?
3. What is your impression of EFP?
4. How would you describe your personal interaction with the horse?
5. How do you see the interaction with the horse impacting your posttraumatic stress disorder symptoms?
6. Describe your own progression through the therapeutic process.
7. What treatments have you tried prior to EFP?
8. How does EFP compare to other treatments?
9. How does EFP differ from other treatments?

Appendix D: Observation Protocol

During the observation phase of the data collection process, the research will focus on the participant and how he or she interacts with the horse and the therapist during the EFP session. If an outside individual at the ranch (e.g. other staff member, barn hand, or participant) should inquire as to the researchers presence, the participant will simply state that the researcher is a friend observing the therapeutic session, which is not uncommon within a ranch setting.

The researcher will ask to observe one EFP session at the participants choosing. The researcher will then sit outside of the arena and observe at a distance, so as not to affect the participant or the horse. The researcher will attempt to schedule the interview and observation phases on the same day. This is intended to minimize the required participation time for the participant. An informed consent will be again signed prior to the start of the observation phase.

Appendix E: Photo Interview

The photo interview process invites participants to answer the research questions by taking specific, meaningful, photos of the experience and then having them explain the photo(s) to the researcher (Kolb, 2008). The photo interview typically moves through four stages:

1. The participant is reminded of the main research question and then is asked to take a photo(s) that reflects his or her perspective on the question.
2. The second phase is the active phase where the participant takes his or her photo(s).
3. In the third phase, participants reflect on the photo(s) and verbalize his or her thoughts in an interview. Questions will include:
    a. Tell me about this photo.
    b. Why is this photo significant to you?
    c. How does this photo represent your therapeutic experience?
4. The researcher analyzes the photo(s) and the recorded interview transcript (Kolb, 2008).

The photo(s) will be taken on a digital camera and viewed on my computer. The brief interview will be recorded on an MP3 player and then uploaded to TranscribeMe. The collected data will then be uploaded to NVivo for analysis and coding. Themes will then be compared to assess for similarities and differences.

Appendix F: Participant Recruitment Script

Community Research Partner Name:
Contact Information:
Date:

Dear Executive/Program Director (personalize):

Thank you very much for your desire to cooperate with my dissertation. Please note that if you wish to change your mind and discontinue cooperation, you may do so at any time throughout the research process. Please allow me to read the follow in script to your Equine Facilitated Psychotherapy Veteran Groups and/or individual sessions:

> Thank you for considering participation in this research study. Please note that this study is not treatment, is completely voluntary, nor will it have any bearing on the quality and/or outcomes of your current treatment (e.g. whether or not you choose to participate). My name is Mark A. Mayfield and I am a doctoral student in the Counselor Education and Supervision program at Walden University. I am conducting my dissertation research on Equine Facilitated Psychotherapy with veteran survivors with full or partial Posttraumatic Stress Disorder. I am recruiting individuals who would be willing to volunteer about 3-4 hours of their time to participate in this study.
>
> Please note that here will be no compensation of this study, and it is completely voluntary. If you would like to participate in this research, please contact me to set up our first meeting. My phone number is (719) 439-8014 and my email is mark.mayfield@waldenu.edu.
>
> Thank you for your time and your consideration!
> Sincerely,
> Mark A. Mayfield MA, LPC, NCC

Thank you again for your cooperation in this study,
Sincerely,
Mark A. Mayfield MA, LPC, NCC