

**Self-Efficacy among Counselors Trained in Animal-Assisted Play Therapy**

by

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## Abstract

The purpose of this study was to examine the participant's level of self-reported counseling self-efficacy when conducting an animal assisted play therapy (AAPT) session. The results indicated that participants had a moderate to high level of self-reported counseling self-efficacy on both the Animal-Assisted Play Therapy (AAPT) questions and the Counselor Activity Self-Efficacy Scale (CASES). The participants' years of clinical experience had a statistically significant effect on three CASES subscales: insight, exploration and session management. The participants' responses on the AAPT measure, CASES, as well as four of the CASES subscales were also statistically significant when the in-person training component of the Playful Pooch training program had been completed. Participants with play therapy credential produced scores were statistically significant on the CASES exploration and session management subscales. These findings as well as others are also discussed.

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## CHAPTER I. INTRODUCTION

Children experience normal anxiety differently depending on age and gender (Barrios & O'Dell, 1989). Children often enter into the counseling setting with heightened levels of anxiety due to exposure to new people and an unfamiliar environment. When working with children in the mental health setting, it is important to understand their level of cognitive development and to choose a therapeutic modality and interventions that are sensitive to the child's world and understanding of new situations. In order to successfully help children cope with life changes, mental health professionals have developed modalities other than traditional talk therapy. Clients under the age of 11 lack the cognitive development to comprehend complex issues, feelings, and motives (Piaget, 1962). As a result, Play Therapy (PT) is an approach used by trained therapists (Bratton, Ray, Rhine & Jones, 2005).

Play is the primary and natural medium of communication for children (Axline, 1947; Erikson, 1963; Landreth, 2002; Piaget, 1962; Russ, 2004; Vygotsky, 1967). Play provides a child with the mechanism for coping, learning, understanding, intelligence, and mastery. Unlike talk therapy, PT requires no verbalization or language. PT is a philosophically conceived, developmentally-based, and research-supported approach to helping children (Landreth, 2002). According to Kottman (2001,b), PT provides activities and atmosphere to help children express themselves, work on their problems, try different solutions, and learn more effective coping strategies through the use of toys such as dolls, puppets, and inanimate objects. These toys assist a child in learning life lessons and problem solving skills, or in identifying difficult emotions.

The literature supports that PT is an effective approach for treating children with an array of emotional and behavioral problems. A meta-analysis demonstrated the effectiveness of PT across client age, client gender, and presenting issue of the client (Bratton, Ray, Rhine & Jones, 2005).

More recently, some play therapists have included animals in their session and have incorporated Animal-Assisted Therapy (AAT). Incorporating a therapy animal into the sessions expands the materials a client can use to work through the issues that he or she brings to therapy. AAT is a goal-directed intervention (Delta Society, 2001). A therapist can incorporate the animal into whatever theoretical orientation they practice. The trained therapy animal may serve as a non-threatening transitional object that the client can develop a relationship with (Levinson, 1969; Winnicott, 1971), resulting in unconditional love and acceptance to the client during the session (Hoelscher & Garfat, 1993; Levinson, 1969; Mallon, 1992; Mallon, Ross, & Ross, 2000). This relationship with the animal can become a catalyst of movement in sessions (Chandler, 2001). The environment becomes more stable and consistent (Katcher, 1983), and is less threatening and safe (Beck, Hunter, & Seraydarian, 1986; Gonski, 1985; Katcher & Wilkins, 1993). The animal is perceived as a normal part of the environment and provides a calming presence (Baun, Bargstrom, & Langston, 1984; Hart, 2000; Mallon, Ross, & Ross, 2000; Wilson, 1991). Pet Partners, a therapy animal registration organization, recognizes the following domesticated animals as eligible for therapy animal evaluation: dogs, cats, guinea pigs, rabbits, domesticated rats, horses, donkeys, llamas, cockatoos, and African grey parrots. For the purposes of this research study, the researcher will focus on the incorporation of dogs into the therapeutic setting.

Animal-Assisted Play Therapy (AAPT) has emerged as an intervention option for families and children over the past decade. It allows the therapist to incorporate a trained animal, such as dogs, to the PT interventions. Through the inclusion of animals in the play room, the trained therapist and animal participate as co-therapists with families and children. Animals play a vital role in children's development (Jalongo, 2004; Melson, 2001). The inclusion of animals in sessions with children has shown to produce many positive outcomes. It increases children's empathy and caregiving, and it provides children with unconditional acceptance (Anderson & Olson, 2006). Children's emotional and physical safety levels are strengthened, and children learn appropriate behaviors with people and animals. Trained dogs can participate in nondirective or directive PT. With nondirective PT, the child has control whether the animal participates in imaginary play, and with directive PT, the children can teach dogs basic obedience tasks. Games such as tug-o-war and chase can assist children in learning better self-regulation. The therapist continually focuses on building relationships. Parent, peer, and sibling relationships benefit from the child's positive interactions with animals (VanFleet, 2008).

Both Play Therapy and Animal-Assisted Therapy focus on alleviating many types of childhood problems including developmental, social, emotional and behavioral concerns (VanFleet & Faa-Thompson, 2010). These two modalities have a firm foundation in research when used separately, but the research is limited when combining the two approaches into Animal-Assisted Play Therapy (AAPT). AAT and PT fields are growing at similar paces, and the research on combining the two is promising (Thompson, 2009; VanFleet, 2008a). In this study, the researcher looked at the level of self-efficacy of counselors trained in AAPT.

The process of gaining self-confidence in particular domains of behavior has been explained by self-efficacy theory for many years (Bandura, 1977a, 1977b, 1982, 1986b, 1989a,

1989b). Bandura (1977b) formally defined self-efficacy as “the conviction that one can successfully execute the behavior required to produce the [desired] outcomes” (p. 193), and as a result, self-efficacy beliefs impact one’s thoughts, motivation, action, affect, and the environment one selects. Since Bandura’s initial research on self-efficacy levels, Larson and Daniels (1998) have come to define counselor self-efficacy as “a counselor’s beliefs or judgments about his or her capacities to effectively counsel a client in the near future” (p. 237). As a key component of a therapist’s development (Hackney & Goodyear, 1984; Kell & Mueller, 1966), self-efficacy is associated with counseling performance (Friedlander, Keller, Peca-Baker, & Oik, 1986; Johnson, Baker, Kopala, Kiselica, & Thompson, 1989), and client outcome (Orlinsky, Grawe, & Parks, 1994; Orlinsky & Howard, 1986).

Perceived self-efficacy is comprised of what a person believes they can do with what skills they possess (Bandura, 1997). It also refers to a person’s judgment about their personal abilities and plays a major role in the self-regulation of motivation (Bandura, 1995, 1997). Bandura (1995) suggests that efficacy beliefs can result in multiple changes in motivation based on how long they persist during a challenging time, the definitions of what goals people set, how much energy is put into those goals, and the person’s resilience to failures. Bandura (1997) identifies four sources from which self-efficacy beliefs are assembled: (a) enactive mastery experiences, (b) vicarious experiences, (c) verbal persuasion, and (d) physiological and affective states. These four sources are used for the selection, interpretation, and integration of information used by individuals to form self-efficacy beliefs.

### **Purpose of the Study**

There is a paucity of research on counselor self-efficacy as it relates to counselors using Animal-Assisted Play Therapy (AAPT) in their practice. The purpose of this study was to

examine the participants' level of self-efficacy when conducting an animal assisted play therapy session. Previous research indicated that counselor self-efficacy is related to their affect and judgments about their ability to effectively provide counseling to a client (Larson & Daniels, 1998). As such, the researcher investigated the factors that may develop self-efficacy among counselors participating in Animal Assisted Play Therapy. The identified potential variables were: (a) years of clinical experience, (b) Play Therapy credential, and (c) the component AAPT training they have completed.

### **Significance of Study**

With the lack of an overarching governing body that regulates training and practice of animal-assisted play therapists, it is important for research to be conducted to evaluate the level of counseling self-efficacy perceived by the therapist who chooses to implement this modality. Bandura (1977a, 1977b, 1982, 1989b) listed vicarious experiences and performances as components of self-efficacy, and these components are part of the AAPT training program that study participants attended. In order to better understand the perceived counseling efficacy of the counselor, a closer look at the relationship between training and self-efficacy is needed. This study looked specifically at what effect PT and AAPT training had on the self-reported counseling self-efficacy levels. Another aspect that can affect self-efficacy is experience. As a result, the investigator inquired into the participant's years of counseling experience, education level, and specialty area. The results of this investigation will contribute to literature in areas of AAPT, PT, and counselor education. The self-efficacy of counselors is important and can fluctuate throughout their professional years.

## **Research Questions**

In order to achieve the purpose of the current study, the following five research questions were developed:

1. What is the level of self-reported counseling self-efficacy among counselors conducting Animal-Assisted Play Therapy?
2. Is there a statistical difference in self-reported counseling self-efficacy by years of counseling experience?
3. Is there a statistical difference in self-reported counseling self-efficacy by educational degree earned?
4. Is there a statistical difference in level of self-reported counseling self-efficacy by component of Animal-Assisted Play Therapy training?
5. Is there a statistical difference in level of self-reported counseling self-efficacy by play therapy credentials?

## **Definitions of Terms**

Several key terms used throughout this study are defined to facilitate a common understanding amongst readers.

**Animal-Assisted Play Therapy (AAPT)** is defined as the use of animals in the context of play therapy, in which appropriately trained therapists and animals engage with children and families, primarily through systematic play interventions, with the goal of improving children's developmental and psychosocial health, as well as the animals' well-being (VanFleet, 2007a, p. 17).

**Animal-Assisted Therapy (AAT)** is defined by Delta Society (2004), a highly respected AAT training organization, as



A goal-directed intervention in which an animal that meets specific criteria is an integral part of the treatment process. AAT is directed and/or delivered by a health/human service professional with specialized expertise, and within the scope of practice of his/her profession. AAT is designed to promote improvement in human physical, social, emotional, and/or cognitive functioning. (p. 11)

**Counseling** – a relationship on the professional level that assists diverse individuals of all ages as well as families and groups to work towards mental health, career, and wellness goals (ACA, 2010).

**Counseling Self-efficacy (CSE)** is defined as “one’s beliefs or judgments about his or her capabilities to effectively counsel a client in the near future” (Larson & Daniels, 1998, p. 180) and encompasses three broad sub-domains of perceived ability, including the ability “to (a) perform basic helping skills, (b) manage session tasks, and (c) negotiate challenging counseling situations and presenting issues” (Lent, Hill, & Hoffman, 2003, p. 98).

**Play Therapy** is defined by the Association for Play Therapy (APT) as “the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development” (APT, 2006, About Play Therapy Overview, para. 5).

## CHAPTER II. REVIEW OF LITERATURE

This chapter is divided into five sections and presents a review of the literature relevant to counselor self-efficacy when providing counseling utilizing the modality of animal assisted play therapy. The first section provides the history and latest research on animal-assisted therapy. The second section discusses play therapy as an approach to counseling young children. The third section introduces the newer modality of animal-assisted play therapy, and the limited research that has been done in this area. The fourth section covers self-efficacy as related to the counselor. Finally, the fifth section ties the other sections together, as a summary of how the sections come together for the purpose of this research study.

### **Animal-Assisted Therapy**

Animal-Assisted Therapy (AAT) is a topic found in many articles. These articles outline the successes and discuss the training programs, the professional organizations, and the increase in trained professionals identifying with this modality. Research has shown that a therapy dog can also play the role of a transitional object for clients (Fine, 2006; Winnicott, 1986). Martin and Farnum (2002) suggest current research documents that therapy dogs have positive effects on communication skills. Through these communication skills and transitional objects, they help the clients regulate their emotions on a more consistent basis and experience catharsis when in the clinical setting. Often, social complications and communication differences pose a challenge for clients entering into new situations. When in a mental health setting that includes an animal, the clients experience safety and predictability. These qualities are projected onto the animal,

and as a result, the relationship has the possibility of providing the clients with support when they choose to take the initiative to enter into new conditions and atmospheres (Winnicott, 1986).

In addition, the animal can be used as a tool for learning skills such as managing emotions and developing appropriate social behaviors. This can be done during their therapy sessions when the therapist may trigger feelings of uncertainty or is perceived as a threat when she brings up difficult issues. Some clients who have insecure attachment may be triggered and have avoidance responses or intense attempts to maintain proximity (Mikulincer & Shaver, 2005). The animal's presence during the therapy process can create an alternative approach that may circumvent difficulties that arise (Parish-Plass, 2008). Current clinicians strive to advance the profession, and clients desire innovative interventions in order to work with their presenting concerns.

Historically, a variety of benefits have been documented in the profession from environments that included animals, including psychosocial and psychophysiological (Chandler, 2005; Ewing, MacDonald, Taylor & Bowers, 2007; Lovaas & Smith, 1987; Nathanson, 1998; Redefer & Goodman, 1989; Wilson & Turner, 1998). The relationship between humans and animals is an important component that researchers recognized when discussing the roots of AAT. The relationship exhibits itself as a rather spiritual regulatory feature (Fine, 2006; Pavlides, 2008). The first documentation of animals as a therapeutic intervention was back in 1792, and in 1919, AAT was officially organized (Pavlides, 2008). This occurred at a St. Elizabeth's psychiatric facility in Washington, DC. Franklin K. Lane, Secretary of the Interior, requested making dogs part of the treatment for patients (Burch, 1996; Chandler, 2005; Hooker, Freeman, & Stewart, 2002). Army veterans were given an opportunity to work on a farm at their convalescent hospital in New York during 1942 (Chandler, 2005; Hooker et al., 2002). Though

these are the first accounts, neither location collected data on the positive or negative effects on their patients (Chandler, 2005). In the 1960s, Boris Levinson, a child psychologist, realized the effect his dog had on his child and adolescent clients' therapy sessions (Chandler, 2005; Hooker et al., 2002; Levinson, 1969, 1997; Pavlides, 2008). His observations resulted in research efforts in the area of "pet therapy" which would later be recognized as the beginning of AAT (Levinson, 1969; Pavlides, 2008).

Hippotherapy had its start in the 1960s and involved using horses during physical therapy sessions (Pavlides, 2008). This resulted in the North American Riding for the Handicapped Association which was founded in 1969 (Chandler, 2005; Fine, 2006). AAT continued to grow during the 1970s in a New York children's residential treatment center. Children with developmental, behavioral, and emotional needs were paired with farm animals (Fine, 2006). In addition, Levinson (1969) valued the human bond with animals and desired to hear about the experiences that his peers in New York were having as they introduced and used animals in their therapeutic practices. He was able to make contact with 435 responders, of which 33% had included pets as "therapeutic aids" (Pavlides, 2008, p. 23) and 57% preferred to keep pets in their homes (Levinson, 1972).

Levinson's work was expanded upon in the 1970s by Sam and Elizabeth Corson, who were psychiatrists at Ohio State University's Psychiatric Hospital (Chandler, 2005; Fine, 2006; Hooker et al., 2002). The researchers conducted pilot studies using animals in nursing homes and hospitals, and the empirical data they collected yielded significant growth of clients in the areas of psychological, social, and physical domains including self-esteem and socialization (Corson, Corson, Gwynne, & Arnold, 1975).

Though there was little empirical data to support AAT, there seemed to be a lot of positive anecdotal reports from clients, families, and other professionals. Associations and organizations were created to support the inclusion of animals in the therapeutic setting (Delta Society, 1996; Kruger & Serpell, 2006; Pavlides, 2008). There were many professionals that outwardly acknowledged the relationship between incorporating animals and meeting the therapeutic and emotional needs of the clients (Levinson, 1997; Serpell, 2006).

In 1977, the Delta Society was founded as a result of professionals seeking more literature and empirical evidence on working with animals in a therapeutic manner. A group of doctors, psychiatrists, and veterinarians who had all supported and witnessed positive results using canines with their patients were determined to support their theories through funded research (Bustad & Hines, 1984; Chandler, 2005; Delta Society, 1996; Kruger & Serpell, 2006; Serpell, 2006). Slowly, data has been gathered and studied. As time continued, more professional fields joined. Specifically, nurses started to publish articles reporting the benefits of including animals for stress reductions and physiological benefits (Biley & Brodie, 1999; Bustad & Hines, 1984; Carmack & Fila, 1989; Cox, 1993; Friedmann, Katcher, Lynch & Thomas, 1980; Hooker, Freeman & Stewart, 2002; Meadows, 2002; Miller & Ingram, 2000).

As experimental research articles were published and reported the benefits in a variety of settings, AAT began to grow more in the early 2000s (Barker & Dawson, 1998; Chandler, 2005; Cox, 1993; Hooker et al., 2002; Mcvarish, 1995; Staats, Pierfelice, Kim & Crandell, 1999); as a result, more materials and resources were available for the professional community (Chandler, 2005). Organizations such as Therapy Dogs Incorporated, the Delta Society, Therapy Dogs International, and the National Center for Equine Facilitated Therapy all currently support AAT

professionals on the local and national levels (Chandler, 2005; Kruger, Trachtenberg, & Serpell, 2004; Pavlides, 2008).

However, AAT has yet to be recognized as an empirically-supported form of treatment. This is partially due to the sparse funding sources for thorough research studies and the limited number of practitioners who are comfortable with this research method (Kazdin & Weisz, 1998). Other disciplines question AAT partially because the modality is lacking a standard definition and a set of guidelines for practice that are widely implemented. A review of the literature yielded many labels that are given to the animal-based interventions, which result in a lack of organization of the literature and the professionals involved. Some of these terms include: “pet therapy,” “animal assisted intervention,” “pet-facilitated therapy,” “Canine therapy,” or “Animal assisted activity” (Pavlides, 2008, p. 70). Validity doubts are increased among professionals, according to Krugerm et al. (2004), as a result of an incoherent theoretical framework to explain the potentially therapeutic benefits of AAT, as well as the statistical, procedural, and conceptual weakness in the methods used to study AAT. Kruger (2004) considers the potential of therapeutic interventions that involve AAT, but the effectiveness of their interventions must yet be validated.

### **Bond between Humans and Animals**

The human-animal bond (biophilia) is a term coined by Wilson in 1984. The natural relationship that forms between animals and humans is the basis for AAT (Bustad & Hines, 1984). The belief backing biophilia is that humans are born with an inclination to be attracted by, and have a curiosity for, other species (Chandler, 2005; Pavlides, 2008). Consistently, research shows that the bond between the client and therapy animal is made quickly (Bustad & Hines, 1984; Cox, 1993; Jones, 1985; Kruger & Serpell, 2006; Meadows, 2002). These

relationships and other interactive experience with the animal can have positive effects on the client's well-being and health (Bustad & Hines, 1984; Cox, 1993; Jones, 1985; Kruger & Serpell, 2006; Meadows, 2002). Positive physiological reactions happen in humans when a friendly and calm animal is present, including decreased heart rate and lower stress levels (Fine, 2000; Katcher & Wilkins, 1998; Levinson, 1997). Specifically, Melson (2000) found this to be more evident in children and adolescents. When an animal is invited into the therapeutic journey, it is important for the therapist to remember that rapport and safety of the environment is the primary concern of the therapist (ACA, 2000; Chandler, 2005).

AAT is discussed often in literature, and authors frequently mention the attraction to animals, but there is a paucity of literature validating the inherently based tendency to care for, and be engrossed by, other living organisms (Kahn, 1997). This does not stop AAT from occurring in the clinical setting as a result of its unique level of engagement during therapy (Kruger et al., 2004).

Maslow, Bowlby and Erikson were theorists that provided a foundation for researchers and theorists surrounding the early childhood years. Security, safety (Heward, 2006), and trust are mandatory for survival (as cited in Chandler, 2005). Researchers reported that cases of AAT with children and youth are evidence of the bond and the attachment that is nurtured in the therapeutic setting with the animal (Bardill & Hutchinson, 1997; Ewing, MacDonald, Taylor & Bowers, 2007; Mallon, 1992). Children have been known to seek out their pet when experiencing negative emotions. Specifically, Rost and Hartman did a study in 1994 and found that 79% of fourth graders in Germany searched for their pet when feeling sad (as cited in Fine, 2006); similarly, Covert, Whiren, Keith and Nelson (1985) studied youth ages 10–14 in Michigan, and 75% of them showed that the presence of their pet was soothing when they were

upset (as cited in Fine, 2006). Forty-two percent of five year-olds reported that they would seek out their pet when they were angry, afraid, or needed to tell a secret (Melson, 1988). In a follow-up study, Melson worked with youth ages 7 to 15. He found that within five minutes of being alone with an unfamiliar dog, 76% of the participants reported that the dog could understand how they were feeling (as cited in Fine, 2006; Melson, 2000). Triebenbacher (2000) also reported that animals are appropriate for children with limited social and cognitive development.

### **Therapeutic Process with an Animal**

A variety of animals have been used by professionals to aid in the therapeutic process (Kruger, 2004; Pavlides, 2008). Akiyama, Holtzman and Britz (1987) comment on the positive impact of animals on the mental health patterns of “social interaction as well as functional and mental health status” (p. 188). There is more literature based on the inclusion of dogs versus other animals. The dog can play different roles in the session, such as co-counselor, transitional object, motivator for participation, and teacher. The important component of each role is the trust and affiliation with the dog rather than attachment (Chandler, 2005). Safety and stress are positively affected by the presence of the dog in session (Barker & Dawson, 1998; Friedmann et al., 1980; Hansen et al., 1999; Nagengast et al., 1997).

Dogs are frequently used in therapy because of their demeanor and ability to support both the client and the therapist (Chandler, 2005). Kruger et al. (2004) points out four reasons for including a dog in session: “(a) unconditional acceptance, (b) safety and comfort experienced by the client, (c) a non-judgmental and non-threatening atmosphere, and (d) rapport easily established” (p. 14). During the session, the therapist is aware of the dog’s body language and the client’s emotional state or stress level, and these can provide clues for the counselor on the pace of the session (Chandler, 2005; Corson, et al., 1975).



It is not uncommon for the therapeutic environment to feel awkward or uncomfortable to clients. Therapists have found that the therapy dog can assist in moderating the interactions between the client and the therapist (Bardill & Hutchinson, 1997; Corson et al., 1975; Levinson, 1969; Mallon, 1992; Minatrea & Martin, 2008; Serpell 2006; Winnicott, 1986). Animals assist in developing rapport (Chandler, 2005; Fine, 2006) and ease anxiety (Levinson, 1972) at the beginning of the therapeutic relationship. Loving bonds are nurtured in children and therapy dogs. This is reported in qualitative studies and anecdotal reports from the clients and their parents (Chandler, 2005, Fine, 2006; Mallon, 1992; Martin & Farnum, 2002; Nathanson, 1998; Redefer & Goodman, 1989). Children who are able to successfully build a bond with the therapy dog are more successful at extending those bonds with another human (Katcher, 2000). The bond between the animal and the client can also act as a motivation for attendance and participation from the client (Holcomb & Meacham, 1989). Counselors may appear less threatening with an animal as the co-therapist.

When the opportunity is provided for the client to teach the therapy animal, the therapist is able to turn the tables and share with the client how the animal is also teaching them. Empirical evidence supports the skill acquisition (Mallon, 1992; Minatrea & Martin, 2008; Pavlides, 2008; Triebenbacher, 2000) including (a) communication skills (Burch, 1996; Netting, Wilson & New, 1987), (b) impulse-control behaviors (Cox, 1993; Katcher & Wilkins, 1998), (c) caretaking practices that lead to improved understanding of personal responsibility (Pavlides, 2008; Walsh & Mertin, 1994), and (d) the ability to read nonverbal cues (Winnicott, 1986).

Animals have long been seen by anthropologists to be filled with symbolic meaning and are commonly used to represent strong feelings that are repressed or hard to communicate (Freud, 1959). Counselors have used animals as a tool for projection of their client's worries and

fears or to encourage heavy topics of discussion. Similar to the symbolic meaning, the animal can be seen as a transitional object to a more socially acceptable level of functioning (Katcher, 2000).

Animals are used in the therapeutic process as models for respect, kindness, and nurturing (Reichert, 1998). The animal is non-judgmental and can increase the client's self-esteem and promote communication. Mallon (1992) went into a residential institution for emotionally disturbed children and conducted daily visits. Mallon found that the positive effect of the dog's presence was not only experienced by the patients, but also the staff. White (2010) conducted a similar study by placing a dog in a residential treatment center for children who were physically violent. The results included the increased occurrence of love and affection shown by the clients.

### **AAT with Other Animals**

Though other animals can be used for AAT, accessibility to dogs has resulted in a larger literature base supporting their use as therapeutic animals in sessions (Pavildes, 2008). Horses and dolphins have also been used in a controlled therapeutic setting. There is limited research done on the inclusion of these animals.

Equine therapy programs have been designed for utilizing horses to facilitate interventions and exercises. Equine therapists/counselors are specifically trained to facilitate experiences that respond to the needs of the individual/group as well as to the horses, and they are typically mental health counselors as well as equine specialists (Pavildes, 2008). Some of the organizations that support horses as therapeutic agents include National Association of Rehab Providers and Associations (NARA) and Equine Facilitated Mental Health Association (EFMHA). The EFMHA (2003) has provided a definition for the term *Equine Facilitated*

*Psychotherapy* (EFP). EFP is an experiential psychotherapy that includes equine(s). It may include, but is not limited to, a number of mutually respectful equine activities such as handling, grooming, longing, riding, driving, and vaulting.

Individuals participating in Dolphin Assisted Therapy (DAT) go into the water, interact with dolphins, and participate in an experience facilitated by the therapist. Betty Smith is credited as being the first to use dolphins therapeutically in the 1970s (Pavrides, 2008). Smith created “The Discovery and Development of Dolphin-Assisted Therapy” in 2003. Her research yielded the following benefits of DAT: (a) a calming effect, (b) an increase of self-sufficient behaviors, and (c) improved sleep patterns (Pavrides, 2008). Nathanson (1998) and Nathanson, Castro, Friend & McMahon (1997) conducted research on the relationship between dolphins and children with intellectual difficulties or other severe disabilities. Findings revealed improvements in memory and an increase in speech production, though flaws have been identified in the research design (Marino & Liliensfeldt, 1998; Pavrides, 2008). Nathanson and colleagues have reported that working with dolphins helps the children’s cognitive processing development (Nathanson et al., 1997). With an increase in interest in DAT, more literature will become available, such as the findings of a study done by Antonioli and Reveley (2005). These authors noticed the difference in positive results between clients suffering from depression who did water therapy alone, and clients who interacted with dolphins.

### **Play Therapy**

Play therapy has become an increasingly popular treatment modality when working with children. This is a result of a recent increase in empirical data supporting the modality, as well as an increased number of trained play therapists. The idea of using toys and play with younger clients as a form of treatment is not new to the counseling field. Some common historical figures

in the area of psychology have encouraged the use of play as an intervention. Freud published an account using play with a child named “Little Hans” (Freud, 1909, as cited in Landreth, 2002, p. 28). Ten years later, Anna Freud and Melanie Klein developed a framework for psychoanalytic play therapy (Landreth, 2002). This type of psychoanalytic play was found to promote ego strength and facilitate expression while uncovering the past (Kottman, 2001b). Relying heavily on the meaning of children’s play was Klein’s way of understanding the child’s unconscious. This differed from Freud’s belief that play created an alliance with the child and provided access to the experiences of the child, rather than on the symbolism of the play. Shifts in theoretical approaches continued to occur. Release Therapy was established by Levy (1938). He felt that there was no interpretation or symbolism needed and that the focus of the session would be on the play itself. The events that the child chose to play out during session provided them with relief of pain and tension, which allowed for healing. The next change was the development of Relationship Play Therapy by Jesse Taft in 1933 and Frederick Allan in 1934. During these sessions, the focus was on not on the past experiences of the child but rather the here and now, and it relied on the therapeutic relationship. The development of non-directive play therapy drove play therapy into mainstream practice.

Adaptations to Carol Rogers’ non-directive therapy from 1947 were instilled into non-directive play therapy by Virginia Axline (1950), which is now known as child-centered play therapy. Sweeney and Landreth (2003) characterize this approach by “The unwavering belief in the child’s capacity towards growth and self-direction...” (p. 80). “In this view, no attempt is made to control a child, to have the child be a certain way, or to reach a conclusion the therapist has decided is important” (Landreth, 2002, p. 89). “The play therapist’s objective is to relate to the child in ways that will release the child’s inner directional, constructive, forward-moving,

creative, and self-healing power” (Landreth, 2002, p. 60). Unlike Freud and Klein who focused on psychoanalysis, Axline believed children would strive to meet their full potential and that the therapeutic relationship fostered that growth. Principles which guide nondirective play therapy are based on Axline’s (1947) work. Themes in the child’s play assist the therapist in understanding how the child develops relationships and allows the child to express feelings while the therapist reflects. This shows respect for the child and allows him or her to find solutions to problems with minimal limits set in the playroom. This provides the child with a relationship unlike any other previously experienced (Landreth, 2002). The unconditional acceptance and bond are the foundation for the relationship in play therapy.

Charles Schaefer and Kevin O’Connor established the Association for Play Therapy (APT) in 1982 (APT, 2014a). The membership in this professional organization has grown rapidly to match the widespread use of the play therapy modality. APT (2006) defines Play Therapy as “the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development” (About Play Therapy Overview, para. 5). The Association provides training, collaboration, and certifications for therapists practicing play therapy.

## **Training**

The demand has increased for well-trained play therapists who can provide services in the school and community settings (Joiner & Landreth, 2005). This need has resulted in an increase in training facilities, registered play therapists, and play therapy supervisors. Play therapy training is offered through the Annual Conference, Approved Centers for Play Therapy Education, E-Learning Center, and various other trainings through Approved Providers and

Universities (APT, 2014b). A graduate certificate can be earned through limited universities after completing a series of courses focused on play therapy citation. Courses offer a lecture and experiential component citation. The content of the courses includes theory, history, individual, group and filial therapy skills, and application (APT, 2010). The Association for Play Therapy offers a resource on their website to locate *Approved Centers of Play Therapy Education*, as well as *Approved Providers of Play Therapy Continuing Education*. The Association for Play Therapy also holds an annual three-day conference, which offers attendees training opportunities on various levels and on an array of topics including ethics, supervision, application, special populations, age specific techniques, theoretical approaches, and research (APT, 2014c).

Ryan, Gomory and Lacasse (2002) reported the results of the Association for Play Therapy's membership survey. The results indicated 40% of the participants have participated in play therapy content courses during their graduate training, and of that, only one-third had play therapy components in their practicum experience. The lack of experiential play therapy and supervision limited their efficacy when working with clients. These findings support the need for effective training to ensure quality play therapists (Lindo, Chung, Carlson, Sullivan, Akay & Meany-Walen, 2012). It was then recommended by Fall, Drew, Chute, and More (2007) that novice play therapists receive support to nurture their professional growth from a registered play therapist supervisor also known as an RPT-S. This is a credential obtained from the APT. This commitment to the field of play therapy is challenged due to a lack of financial resources, adequately equipped playrooms, or availability of playrooms at their respective universities (Joiner & Landreth, 2005).

## **Toys**

The atmosphere that is created by the play therapist should be well stocked with specific toys and should be inviting for the client (Landreth, 2002). The benefits of toys as therapeutic agents was recognized in the early 1900s, and Anna Freud (1946) went on to say that children use toys to represent the world they are in and learn to manage and manipulate materials. Axline (1947), Kottman (2001a), and Landreth (2002) have included in their publications recommendations for toys available in the playroom. These recommendations are not specific to the therapist's theoretical approach. Toys used for therapeutic needs could be separated into specific categories: (a) psychotherapeutic toys, (b) artistic materials, (c) hand puppets and portable stage, and (d) portable furnished dollhouse (Cassell, 1972). More recently, the recommendation is that toys are selected cautiously, based on therapeutic and expressive needs of the child (Landreth, 2002).

## **Theories and Approaches**

There are a variety of theoretical approaches to play therapy. Two categories that arise are directive and non-directive. Non-directive play therapy allows the child to guide the session, whereas in directive or structured play therapy, the therapist guides the session in order to move in a particular direction (Gil, 1994). Some therapists choose to follow different approaches based on the client's (a) character, (b) presenting issue, and (c) stage in therapy (Rasmussen & Cunningham, 1995). The need of the child must be evaluated in order to determine the willingness or ability to participate in directive activities (Berting, 2009). Some children are not ready for directive techniques as a result of behaviors such as disengagement and refusal to participate.

Virginia Axline's contribution to play therapy was the foundation of non-directive play therapy (Landreth, 2002). She believed that the child communicates through play what they cannot express verbally, and this is done with very little interpretation or guidance from the therapist (Axline, 1947). The therapist-child relationship is based on the principles of (a) genuineness, (b) unconditional positive regard, and (c) empathy (Astramovich, 1999). Through unconditional acceptance, a child will progress in the session in order to reach their full potential (Ray, Blanco, Sullivan, & Holliman, 2009).

In 2002, Gary Landreth expanded upon Axline's beliefs from 1947 and developed child-centered play therapy. In child-centered play therapy, the client leads the session, allowing the child to grow and feel understood (Moustakas, 1959). The focus is not on the presenting issue or problem, but rather on the acceptance of the child and an environment of respect. This environment is created by providing undivided attention to the child and limiting the number of questions asked or instructions given by therapist (Gil, 1994). Child-centered play therapy is a very common theoretic approach for therapists who practice play therapy (Ryan, Gomory, & Lacasse, 2002). In their 2002 study, Ryan, Gomory and Lacasse found that most universities teach the child-centered model. Another study also found that 66.6% of practitioners identified with the child-centered theoretical orientation (Lambert, LeBlanc, Mullen, Ray, Baggerly & White, 2005).

Unlike child-centered play therapy, directive approaches or structured play therapy incorporate planned activities based on the symptoms of the child (Jones, Casado, & Robinson, 2003). The therapist is responsible for the selection of the activities and topics for each session based on the child's developmental level (Jones et al., 2003). McCalla (2004) reminds therapists to consider chronological age, developmental age, and the cultural environment of the



client in order to properly understand and respond to the child's play in session. Some activities frequently used in directive play sessions are bibliotherapy, role-play, and art therapy, as well as cognitive behavioral techniques (Rasmussen & Cunningham, 1995).

Other theoretical approaches include Gestalt, Jungian, Adlerian, and psychoanalytic play therapy. Oaklander (2001) states that Gestalt Play Therapy allows the therapist to focus on the complete child, which includes the emotional state, the mind, and the physical body of the child. Oaklander (2001) used the analogy of dancing with the client. She says sometime she leads, while other time the client leads. Her focus is on the progression toward homeostasis through music, clay, puppetry, and artwork (Oaklander, 2001). Relationship building, observing sense of self, self-nurturing, and termination with the ending goal being that the child is able to accept responsibility for their choices and build a healthy sense of self are named the stages of Gestalt Play Therapy (Botha & Dunn, 2009)

Jungian analytical play therapy (JAPT) describes play therapy as “a creative, play-based treatment approach that both meets children where they are developmentally, and integrates more directive techniques to help reshape disordered behaviors” (Green, 2008, p. 103). Just like Jungian therapy for adults, the archetypal focus and the collective unconscious are used to promote psychological wellbeing. This is a form of directive therapy with a foundation of trust. One common technique used in Jungian play therapy is sand play (Bainum, Schneider, & Stone, 2006). During this time, the child is allowed to place objects in the sand, which is representative of the dream state. The client's unconscious is projected through this nonverbal imaginative therapy. The cross-cultural archetypal symbols (such as the mother) used in the child's play were identifiable to trained Jungian play therapists (Peery, 2002).

Adlerian play therapy uses components of both non-directive and directive play therapy (Kottman, 2001a). Some of the following techniques are used in play sessions: (a) encouragement, (b) family constellation, (c) early recollections, (d) goal disclosure, and (e) tentative hypotheses, even though the child may be unable to understand the abstract symbols due to developmental immaturity (Kottman & Warlick, 1989). Sweeney, Minnix, and Homeyer (2003) focused on the rationale behind the clients' actions in relations to their goals. The therapist must be cognizant of the limited cognitive development in children, which could result in verbal expression of private thoughts that may challenge the client and relationally drive their goal-oriented play. Watts and Garza (2008) described the Adlerian play therapy phases as: (a) development of the relationship, (b) exploration of the child's style, behaviors, and maladaptive beliefs, (c) increasing the child's insight, and (d) educational significance of and interactions with others.

Substantial developments in play therapy came from Melanie Klein and Anna Freud's psychoanalytic play therapy. Free association in psychoanalysis was used by Klein (1955) with children under the age of six. Interpretation of unconscious motivation and rapport building was done by Anna Freud (1946) through play therapy. The therapist's role in psychoanalytic play therapy is to guide, interpret, and build an alliance with the child (McCalla, 1994). The use of therapeutic games allows the therapist to observe client's drives, defenses, and conflicts within the session (Swank, 2008).

Play therapists, regardless of theoretical approach or technique, need to be aware of the child's developmental level and must be mindful of the child's ability to engage in the session. It is important for the therapist to be aware that client populations are changing and should be prepared to work with a variety of populations (Kottman, 2001b). The inclusion of animals into

play therapy sessions is one approach taken by some therapists to assist in the therapeutic process.

### **Animal-Assisted Play Therapy**

The use of a trained animal in the therapeutic setting with children and therapeutic play is an area of literature that is lacking. One advantage for including animal-assisted therapy (AAT) into the child-centered playroom is to increase the opportunity for reflection of feelings and behavior (George, 1988). This was further expounded by George (1988), who also discussed the benefits of increased self-worth, empathy, and self-esteem that can be experienced when the therapy animal is able to participate in the child's fantasies, stories, and role plays.

Reichert (1994, 1998) published her experiences when working with sexual abuse victims between the ages of 9 and 13. During the investigation, Reichert used AAT in the individual and group counseling settings. A trained therapy dog was initially used to decrease levels of anxiety during the first sessions. She then incorporated the animal into directive and non-directive activities with the children. She reported that having the animal created a nonjudgmental environment and supported the client's disclosure of abuse and expression of feelings. Reichert focused on doing these tasks through storytelling activities. Based on her findings, animals can serve as a link between the therapist and the child. Specifically, the projection and identification of the child's feelings during the storytelling supported the client's movements towards meeting treatment goals (Reichert, 1994, 1998).

More recently, an exploratory qualitative study was conducted by Risë VanFleet (2007b). She sought to find out how practicing play therapists included animals in their sessions. The study used an open-ended survey to promote responses from participants. The sample was recruited from the Association of Play Therapy (APT) through electronic contacts with APT

branch presidents and by verbal announcements made at professional conferences where VanFleet had presented. Her study yielded results from 83 participants representing an average of 10 years of experience as a play therapist. Ninety-seven percent (97%) held licenses in their respective state, 33% had obtained their RPT-S, and 33% had their RPT (VanFleet, 2007b). Seventy-five percent of participants utilized a therapy dog, and 25% had fish in the office. The other therapy animals mentioned were cats, rabbits, horses, geckos, anoles, snakes, chickens, and squirrels.

Fifty percent of the participants reported incorporating the animals in their play therapy work “some of the time”, while 42% reported “most of the time” (VanFleet, 2007b). Of the participants, 58% reported being self-educated and 42% had training from an organization or graduate coursework. As for their therapy animals, 58% reported no formal training for their animal, and 42% of the animals had earned certification from the Delta Society or Therapy Dogs International. The participants all reported about the increased responsiveness from the child when the animal was present in the session (VanFleet, 2007b). The relationship between the animal and child was evident when the participants reported that clients would ask for the animal if it was not present.

Pet Partners, also known as Delta Society, Animal Behavior Institute, Animals and Society, and Hand in Paw, have established trainings, resources and some offer certifications in Animal-Assisted Therapy. Playful Pooch is currently the only organization that offers a certification specifically in Animal-Assisted Play Therapy. The approaches, populations they target, and the setting for interactions may vary, but all these organizations strive to work with the clients to improve their well-being.

Playful Pooch is a program that is specialized in offering various training and certification opportunities for mental health professionals who desire to be trained as Animal-Assisted Play Therapists. The program has been offering trainings since 2007. Over time, the program has evolved from overview workshops in 2007, to three-day workshops in 2008, to the current four-day format in 2010. As of 2012, participants are also required to complete the online courses prior to attending the four-day in-person training (VanFleet, 2013a+). These trainings currently incorporate online course work, outside reading, live skills-building courses, practical assessments, and supervised practice (VanFleet, 2013a). In order to become a Certified Professional Practitioner of Animal-Assisted Play Therapy, one must have a master's degree in mental health of education, be licensed to practice independently in their state, have a play therapy certification, and attend and participate in the training components listed above (VanFleet, 2013a). "This certification is based on the demonstrated competence of the human handler ... this certification is designated to place utmost importance on the well-being of both the client and the animal" (VanFleet, 2013a, p. 3). This specific training program was used for this study because the trainer has been facilitating AAPT trainings since 2007, has published and done research on AAPT, and she is known in the field as an expert in AAPT (VanFleet, 2013b).

A therapist's level of self-efficacy in PT, AAT, and AAPT influences their goals, the amount of effort put towards those goals, and the level of dedication they have towards those goals when challenges or obstacles arise (Cook, 2010). Following is a review of the self-efficacy and specifically the counselor self-efficacy discussed in existing literature.

### **Self-Efficacy**

The theory used to comprehend the process of increasing confidence level in particular domains such as achievement, coping ability, and counseling skills is called self-efficacy

(Bandura, 1977a, 1977b, 1982, 1986b, 1989a, 1989b). Social cognitive theory was developed by Bandura based on the component of self-efficacy. He felt that changes in behavior occur with reinforcement as well as cognitive representations of information from direct, vicarious, and symbolic sources (Bandura, 1977b). The foundation of motivation is cognitive activities that are representative of future consequences or rewards. The motivation then results in behavior modification (Bandura, 1977b). To translate this information, self-efficacy is the cognitive instrument for human behavior. Self-efficacy is defined as “the conviction that one can successfully execute the behavior required to produce the [desired] outcomes” (Bandura, 1977b, p. 193). Bandura (1989a) stated, “Among the mechanisms of personal agency, none is more central or pervasive than people’s beliefs about their capabilities to exercise control over events that affect their lives” (p. 1175). In order for a performance to be successful, the person must have a basis of knowledge and skills, see the relevance in the particular behavior, and have a belief that they can be successful. In 1977, Bandura projected that self-efficacy expectations have more impact on behavior than outcome expectations. A person’s thoughts, motivation, action, affect, and environment are affected by one’s self-efficacy beliefs (1977a, 1982, 1989a). These self-efficacy beliefs then impact goal-setting; more specifically, the higher a person’s self-efficacy, the higher goals they set for themselves and the more likely they are to attain their goals. Effort level and the ability to visualize a successful outcome are factors contingent on self-efficacy level and effect success level (Bandura, 1977b, 1982, 1989a). Low levels of self-efficacy have been connected to depression, anxiety, fear, and distress (Bandura, 1989b).

Environment selection is also impacted by the range of coping skills. Humans prefer to be in environments where their perceived ability to cope with the associated demands is congruent with the actual demands of the environment. If these environmental choices are made

successfully, then positive results occur and the values, interests, and competencies of the individual are strengthened (Bandura, 1989a). Expectations of self-efficacy are categorized in three ways: (a) magnitude-task difficulty, (b) generality-limitations of the task, and (c) strength-degree of success in accomplishing the given task (Bandura, 1977b).

Emotional reactions and behaviors of a person with high self-efficacy levels and outcome expectations result in optimism, and the person has an increased likelihood to attempt the task at hand. If a person has high self-efficacy but a decreased level of outcome expectation, then he/she will be more pessimistic or attempt to change components of the task or environment. Some people experience both low self-efficacy and low outcome expectation, which results in a higher level of apathy, and the likelihood of resignation is increased. Hopelessness and self-devaluation occur when the person has low-self-efficacy and high outcome expectations.

Self-efficacy comes from (a) performance, (b) vicarious experiences, (c) verbal persuasion, and (d) emotional arousal (Bandura, 1977a, 1977b, 1982, 1989b). Successful performances increase a person's level of personal mastery and results in elevated expectations, whereas if repeated failures occur, expectations levels are lowered. The ability to observe or imitate a person completing the desired task results in increased self-efficacy but is dependent on the social comparison. This social comparison is vital because similarities in age and expertise impact the level of the perceived self-efficacy. Encouragement is a form of verbal persuasion and is frequently used to help people believe that they can successfully complete the task at hand. Disconfirming experiences decrease self-efficacy and as a result, the impact of verbal persuasion is reliant on: (a) credibility, (b) prestige, (c) trustworthiness, (d) expertise, and (e) the confidence of the persuaders. Heightened arousal levels result in negative performance outcomes, and the expectation for success is increased when the participant is not experiencing

an increased arousal level. Cognitive interventions can also be used to heighten one's sense of personal control over the aversive situation, and thus self-efficacy.

Self-efficacy theory has been studied in multiple domains to determine the analytical generality of the theory. Perceived self-efficacy predicts degree of change in diverse forms of social behavior, according to Bandura (1982). Self-efficacy is related to success levels in weight loss, alcohol treatment, smoking cessation, and AIDS prevention (O'Leary, 1992), academic performance (Tuckman, 1990), depression (Davis-Berman, 1990), job burnout (Meier, 1983), maternal competence (Teti & Gelfand, 1991), athletic performance (Gould, Hodge, Peterson, & Giannini, 1989), managerial decision-making (Bandura & Jourden, 1991), physiological reactions (Bandura, Reese, & Adams, 1982), job satisfaction and performance (Saks, 1995), and coping ability (Ozer & Bandura, 1990).

### **Counselor Self-Efficacy**

Counselor self-efficacy has been studied since the 1980s (Friedlander & Snyder, 1983; Munson, Stadulis, & Munson, 1986; Munson, Zoerink, & Stadulis, 1986). Counselor self-efficacy is defined as "a counselor's beliefs or judgments about his or her capacities to effectively counsel a client in the near future" (Larson & Daniels, 1998, p. 180).

The studies mentioned below utilized a variety of instruments to better understand the variance in counselor-self-efficacy. Since the 1980s, there have been multiple instruments developed to measure perceived counseling self-efficacy (Larson & Daniels, 1998). Some focus on counselors-in-training microskills such as: the Counselor Behavior Evaluation-Self-Efficacy (CBE-SE; Munson, Stadulis, & Munson, 1986); the Interpersonal Skills Efficacy Scale (ISES; Munson, Zoerink, & Stadulis, 1986); the Counselor Self-Efficacy Scale (CSES; Johnson et al., 1989); and the Counseling Self-Estimate Inventory (COSE; Larson, Suzuki, Gillespie, Potenza,



Bechtel, & Toulouse, 1992). Other instruments have been developed based on specific situations or settings. Melchert, Hayes, Wiljanen and Kolocek (1996) developed the Counselor Self-Efficacy Scale (COSES) to assess the counseling self-efficacy of trainees for both group and individual counseling. Friedlander and Snyder (1983) designed the Self-Efficacy Inventory (S-EI) for practitioners in the areas of assessment, group, family, and case management counseling. Sutton and Fall (1995) created the Counselor Self-Efficacy Survey (CSS) for assessing the efficacy of school counselors. The instrument used for this study, the Counselor Activity Self-Efficacy Scales (CASES; Lent et al., 2003), is one of the newer instruments designed to measure counseling self-efficacy. It was developed based on Hill and O'Brien's (1999) Helping Skills Model and is an extension of Bandura's (1986) social cognitive theory.

Training programs for counselors typically incorporate sources of self-efficacy, which allows counselors to develop self-confidence through coursework, observations, and role plays as well as practicum and internship placements. Some components that have been found to increase levels of counselor self-efficacy are: experience with clients, supervision sessions, and counseling coursework (Kocarek, 2001; Larson & Daniels, 1998; Leach, Stoltenberg, McNeill, & Eichenfield, 1997; Lent et al., 2003; Melchert, Hays, Wiljanen, & Kolocek, 1996; O'Brien, Heppner, Flores, & Bikos, 1997). At this time, there is inadequate research supporting training format and variance in counselor self-efficacy.

Predictors of counselor self-efficacy have been identified through regression analyses. Some of these significant predictors are environmental perceptions, positive feedback, and counselor characteristics (Alvarez, 1995; Daniels, 1997). Specifically, 80% variance in counselor self-efficacy was related to anxiety, prior self-efficacy levels, and feedback (Daniels, 1997). Bandura's (1982) study also found a connection between self-efficacy levels and anxiety

levels. A study conducted by Melchert and colleagues (1996) found that experience level and training accounted for 43% of counselor self-efficacy variance. Watson (1992) conducted a similar study and discovered that coursework and experience related to counseling accounted for 35% variance in counselor self-efficacy. These findings, in addition to others, support the connection between training and experience to counselor self-efficacy. At this time, there is inadequate research supporting training format and variance in counselor self-efficacy.

### **Summary of Literature**

This chapter discussed history, training, and theory behind the different approaches of animal assisted therapy, play therapy, and animal assisted play therapy. Self-efficacy and counselor self-efficacy were also explored to support this study. Though there is limited research on the relationship between training and self-reported counseling self-efficacy when conducting Animal-Assisted Play Therapy sessions it has been widely supported that there is a positive correlation between training and experience and counselor self-efficacy in general. This approach is supportive of children's development when facilitated by a counselor who feels effective in practicing AAPT.

## CHAPTER III. RESEARCH METHODS

This chapter discusses the research design and methods used by the researcher to understand the relationship between animal-assisted play therapists' self-reported counseling self-efficacy and their experience and training. The chapter includes the research questions, a description of the research design, participants, measures, data collection, and data analysis.

### **Research Questions**

The following five research questions below will provide a framework for this study.

1. What is the level of self-reported counseling self-efficacy among counselors conducting Animal-Assisted Play Therapy?
2. Is there a statistical difference in self-reported counseling self-efficacy by years of counseling experience?
3. Is there a statistical difference in self-reported counseling self-efficacy by educational degree earned?
4. Is there a statistical difference in level of self-reported counseling self-efficacy by component of Animal-Assisted Play Therapy training?
5. Is there a statistical difference in level of self-reported counseling self-efficacy by play therapy credentials?

### **Research Design**

A cross-sectional survey research design was adopted for this study. The measures used for the current research study include demographic survey questions, the Animal-Assisted Self-

Efficacy measure, and the Counseling Activity Self-Efficacy Inventory (Lent, Hill & Hoffman, 2003) to collect quantitative data. In addition, five qualitative questions were asked as part of the demographic questions. These survey measures were distributed to potential research participants using the online survey software Qualtrics. Qualtrics allowed collected survey data to be downloaded and imported into IBM SPSS Statistics for Windows for data analysis. Descriptive statistics and analysis of variance (ANOVA) was used to analyze the data. The dependent variables in this research study were the AAPT self-efficacy measure scores, the overall counseling self-efficacy scores and the six subscales scores of the self-efficacy measure. The independent variables were level of AAPT training, years of counseling experience, level of education, and presence of Play Therapist credentials.

### **Participants**

Nonrandom purposeful sampling was used for the current research study. Johnson and Christensen (2008) defined purposeful sampling as occurring when the researcher specifies the characteristics of the population of interest and locates individuals with those characteristics. Recruitment was focused on participants who had attended the Animal-Assisted Play Therapy training program through Playful Pooch. Playful Pooch is an organization that offers animal assisted play therapy services to children and families as well as training opportunities for mental health professionals. Playful Pooch was chosen for this study because the program provides trainings on multiple levels in various states and countries, and the trainer has published and done research on Canine-Assisted Play Therapy. She is known in the community as a leader in this field. In addition, inclusion in this study was limited to those over the age of 19. As a part of the recruitment process, a link was sent to the Playful Pooch's AAPT training participants and posted on the AAPT Facebook page. Accompanying this link was the informational letter about

participation in this study as well as the measures being used in the study. No identifying information was collected from the participants, and participation in the study was voluntary.

A power analysis was conducted in order to determine the sample size required to detect a small to medium effect size ( $d < .05$ ) with a given degree of confidence ( $p < .05$ ) to determine the minimum number of participants needed. The estimated minimum number of participants needed for this study was 75 (Cohen, 1988).

### **Measures**

The survey used for the study combines an existing measure, the Counselor Activity Self-Efficacy Scale (Lent, Hill, & Hoffman, 2003), with three other sets of questions developed by the investigator. They include seven questions to assess AAPT Efficacy, demographic questions, and five qualitative questions to collect individual perspectives on their training and process of implementing AAPT further in depth.

#### **Counselor Activity Self-Efficacy Scale**

The Counselor Activity Self-Efficacy Scale (CASES; Lent, Hill, & Hoffman, 2003) was developed to assess one's counseling self-efficacy. The authors conceptualized counseling self-efficacy as encompassing three broad domains, including perceived ability to perform discrete helping skills (e.g., reflection of feeling), to manage routine session tasks (e.g., conceptualizing the client), and to handle challenging clinical situations (e.g., a severely depressed client). The CASES is composed of 41 items, divided into six subscales. All items are arranged on a 10-point Likert-type scale ranging from no confidence (0) to complete confidence (9). Higher subscale and total scores indicate higher self-efficacy. Thus, possible scores range from 0 to 369 (Lent, Hill, & Hoffman, 2003).

A factor analysis was done on each of the three domains. This analysis revealed six subscales to overall counseling self-efficacy: (a) exploration skills, (b) insight skills, (c) action skills, (d) session management, (e) client distress, and (f) relationship conflicts (Lent, Hill, & Hoffman, 2003). The Exploration Skills subscale is composed of five items that measure one's perceived ability to develop a facilitative counseling relationship and elicit necessary information from the client (e.g., using reflection and open-ended questions). The Insight Skills subscale contains six items that measure one's perceived ability to help the client develop an understanding of his/her problems (e.g., using immediacy statements and challenging client contradictions). The Action Skills subscale is composed of four items that measure one's perceived ability to promote change in client thought, behavior, or affect (e.g., providing direct guidance and role-playing). The Session Management subscale is composed of 10 items designed to capture one's perceived ability to manage a variety of common counseling tasks (e.g., using the correct counseling skills based on the client's needs at a given moment and helping one's client discuss concerns at a deep level). The Client Distress subscale is composed of six items and measures one's perceived ability to work effectively in highly challenging situations (e.g., seeing a client who has experienced a traumatic life event). Finally, the Relationship Conflict subscale is composed of 10 items and measures one's perceived ability to handle relationship conflict (e.g., sexual attraction, manipulation). The first four subscales correspond to basic skills, whereas the last two subscales correspond to more advanced skills.

Lent and colleagues (2003) calculated internal consistency, test-retest reliability, convergent validity, and discriminate validity estimates. They administered the CASES to a sample of undergraduate and master's level students from five universities enrolled in a helping skills training course, master's level students enrolled in a practicum, and doctoral level students

enrolled primarily in counseling psychology programs ( $n = 393$ ). The students ranged in age from 20 to 57 years ( $M = 26.32$ ,  $SD = 7.46$ ). Reliability estimates for the individual subscales ranged from .79 (Exploration Skills) to .94 (Session Management and Client Distress), providing evidence of internal consistency. The total CSE score for the CASES had an alpha coefficient of .97. Inter-correlations among the individual subscales were medium to large, ranging from .44 (Exploration Skills and Client Distress) to .72 (Client Distress and Relationship Conflict, Session Management and Exploration Skills, and Session Management and Insight Skills). In Lent and colleagues' study, the two-week test-retest reliability revealed consistency coefficients similar to the estimates of internal consistency (Exploration Skills = .81; Insight Skills = .85; Action Skills = .78; Session Management = .93; Client Distress = .91; Relationship Conflict = .94; CASES total = .96). Correlations of the CASES scales with a social desirability measure suggested that the CASES scales are not substantially affected by social desirability bias.

The investigator received approval to make any needed modification to the instrument from the developer (see Appendix 1). These modifications include adding "animal-assisted play therapy sessions" to the directions, removing the one week time constraint in the directions, changing the word "talk" to "increase awareness" in Part II question 4, changing "client" to "client's parents" in question 6 of Part II. Also, a not applicable, or "NA" response option was provided to participants in Part III. To ensure the reliability of the modified measure a Cronbach's  $\alpha$  analysis will be conducted.

The developer informed the researcher that adequate psychometric characteristics would need to be proven. This was accomplished by sharing the modified instrument with experts in the field. To ensure the measure's internal consistency, Cronbach's alpha coefficient of reliability was run.

### **AAPT Self-Efficacy Measure**

This measure was researcher developed based on a review of literature (Chandler, 2005; Thompson, Mustaine & Weaver, 2008; VanFleet, 2008b) and the learning objectives of the Playful Pooch training program (VanFleet, 2013a). The measure includes seven questions on a Likert scale. The measure included questions on animal selection, socialization and training, the ability to read dog and human body language, and the ability to focus on the well-being of the client and animal at the same time. The measure was reviewed by three experts in the field in order to provide evidence of content validity.

### **Demographic Measure**

A demographic survey was developed for the purpose of this study. Questions included information assessing gender, race/ethnicity, age, play therapy credentials, training in animal-assisted play therapy, years of counseling experience, and degree earned.

### **Open-Ended Questions**

For this study five open-ended questions were developed allowing the participants to give qualitative feedback to their individual experience. These questions were developed by the dissertation committee during the proposal meeting. The purpose of these questions was to support the quantitative results.

### **Data Collection Procedure**

The researcher secured approval to collect data from the Auburn University Institutional Review Board (IRB; see Appendix 2). Permission to use the CASES measure was obtained via email from R. W. Lent (see Appendix 3). Permission was obtained by Risë VanFleet to distribute the survey among the participants of her animal-assisted play therapy training sessions at Playful Pooch (see Appendix 4). The survey measures were converted by the investigator to



an online instrument using Qualtrics to increase the ease of survey distribution and data collection. The survey link was distributed by VanFleet via email to her training participants as well as on her Facebook page. The survey was available on Qualtrics for 30 days. The link was redistributed on the 10<sup>th</sup> and 20<sup>th</sup> day by Dr. VanFleet via email and Facebook. Responses to the online survey were collected electronically and downloaded to the Statistical Package for the Social Sciences version 20 (SPSS). The data was kept by the researcher on an encrypted flash drive and in an encrypted folder in DropBox. No identifiable information was collected for this study. As an incentive to complete the survey, survey participants were informed that the investigator would donate \$1.00 to the American Humane Association for each completed survey submission.

### **Data Analysis**

Quantitative analyses are used in this study, including descriptive statistics and analysis of variance. In order to examine the demographic variables and to answer question one descriptive analysis were used. A one-way analysis of variance (ANOVA) was conducted to test the significance of group differences for questions 2 through 5.

Responses to the open-ended questions were analyzed by hand using open coding. Open coding created themes that were grouped together into categories and subcategories for the purpose of comparison (Corbin & Strauss, 1990). This method begins by creating an initial codebook (Creswell, 2007), which is then revised and expanded throughout the analysis process. The data was then scored by frequency (Ross & Shannon, 2008). Although the design of this study includes open-ended questions, their purpose is to complement the findings of the results of the quantitative data.

## **Summary**

Chapter three described the research methodology and analysis conducted for this study. Five research questions were listed and then the research design to address the research questions was presented. Qualifications for research participants, measures used, and data collection procedures were addressed. For this study, descriptive and a one-way analysis of variance (ANOVA) were used with the quantitative data, and hand coding was used with the open-ended questions.

## CHAPTER IV. FINDINGS

The purpose of this study was to examine the participant's level of self-reported counseling self-efficacy when conducting an animal assisted play therapy (AAPT) session. Specifically, this study investigated if years of counseling experience, degree earned, component of Playful Pooch training, and play therapy credentials had a statistically significant effect on the self-reported counseling self-efficacy measures. In this chapter first demographic information of the participants were presented. Next, reliability statistics of adopted measures for current participants were reported. Data analysis results for each research question were followed in order.

### **Demographics**

This study included demographic questions which generated descriptive statistics.. Approximately 200 Playful Pooch training attendees received the survey link which was distributed via email and Facebook by Risë VanFleet. The online survey had 81 participants which yields a 40% response rate. Of these 81 participants, 4 participants indicated that they had not attended the Playful Pooch training, and 14 (17%) failed to complete at least 50% of the questions. This resulted in 67 participants who fully completed the surveys that were included in the data analysis. Of the 67 participants, 66 identified as female and 1 identified as both male and female. The ages of the participants were widely ranged (25–67), with the majority being ages 50–59 (40.2%) or over the age of 60 (32.8%). The mean age was 51.92. A majority of the participants indicated that the highest degree they had earned was a master's (71.6%), with the

remaining participants having obtained a doctoral degree (22.3%) or bachelor's degree (5.9%). The participants indicated a variety of degree programs: clinical mental health counseling (16.4%), school counseling (11.9%), marriage, couple, or family counseling (6.9%), counseling psychology (7.4%), clinical psychology (7.4%), school psychology (2.9%), counselor education, (4.4%), rehabilitation (1.4%), and other (37%). Of these "other" responses, 14 (20.8%) participants wrote in "social work" as their degree program.

The participant's credentials and licenses included licensed marriage and family counselors (32.8%), licensed social workers (32.8%), licensed mental health counselor or licensed professional counselors (29.8%), national certified counselor (19%), licensed psychologist (16%) and certified school counselors (11.9%). Additionally, 35 (52%) had earned a play therapy specific credential and 32 (47.7%) had not. Of the 67 participants, only 46 reported their years of clinical experience. Their responses ranged from 0 to 35 ( $M = 15.97$ ) years. The study participants all completed some component of the Playful Pooch training program between 2007 and 2014. As a result of the evolution of the program, participants who attended between 2012 and 2014 were required to complete online courses prior to attending the in-person training. Prior to 2012, participants did not have this training component available to them. The majority of participants (39, 58.2%) indicated only attending the in-person training component, while 23 (34.3%) reported participating in both the in-person as well as online training components. Five (7.5%) of the participants had completed only the online component of the training.

For the purpose of data analysis, four demographic data sets were regrouped to produce meaningful outcomes. Highest degree was reduced to two groups: master's (71.6%) and post-master's (22.4%). Professional Certifications and Licenses was reduced to two groups: Play

Therapy credentialing (52.2%), and No Play Therapy credentialing (47.8%). Years of clinical experience was reduced into three groups: 0–10 years (28.3%), 11–20 years (19.4%), and 21 or more years (20.8%). The component of Animal-Assisted Play Therapy Training was reduced to three categories: online only (7.5%), online and in-person (34.3%), and in-person only (58.2%) (see Table 1).

Table 1

*Descriptive Statistics of Final Participants*

Descriptor	Variable	Frequency N	Frequency %
Highest Degree (n = 63)	Master's	48	71.6%
	Post Master	15	22.4%
Professional Certifications and Licenses (n = 67)	Play Therapy Credentialing	35	52.2%
	No Play Therapy Credentialing	32	47.8%
Years of Clinical Experience (n = 52)	0–10	19	28.4%
	11–20	13	19.4%
	21 or more	20	20.9%
Component of Animal-Assisted Play Therapy Training (n = 67)	Online Only	5	7.5%
	Online and In-Person	23	34.3%
	In-person Only	39	58.2%

**Reliability Statistics**

In order to assess the reliability of the CASES and the AAPT Self-Efficacy measures, Cronbach's  $\alpha$  was computed as a measure of internal consistency for total scale and subscale. When the measures were evaluated for normality, the results indicated a negative skew, which

resulted in a non-normal distribution. In order to normalize, the data set was transformed. The responses were trichotomized to represent low, medium, and high levels of self-efficacy. This adjusted the skewness in each measure. For this research study, two instruments were used and resulted in reliability greater than .80 with and without transformation as indicated in Table 2.

Table 2

*Reliability and Scale Statistics of Measures Administered with Current Participants*

Scale	Cronbach's $\alpha$ - raw	Manipulated A
Animal-Assisted Play Therapy Self Efficacy Questions (7 items)	.966	.825
Counselor Activity Self Efficacy Measure (CASES) (41 items)	.982	.975
CASES Insight Subscale (6 items)	.96	.953
CASES Exploration Subscale (5 items))	.972	.954
CASES Action Skills Subscale (4 items)	.927	.929
CASES Session Management Subscale (10 items)	.98	.961
CASES Relationship Conflict Subscale (10 items))	.931	.970
CASES Client Distress Subscale (6 items)	.914	.949

**Research Question #1: What is the level of self-reported counseling self-efficacy among counselors conducting Animal-Assisted Play Therapy?**

The self-efficacy of the participants was investigated utilizing two measures, the Animal-Assisted Play Therapy (AAPT) measure and the Counselor Activity Self Efficacy Scale (CASES). Participants indicated their responses on the 0–9 Likert scale: 0 = No Confidence, and 9 being = Complete Confidence. These responses were transformed to decrease skewness and

allow the responses to represent a distribution closer to normal. In order to ease in the interpretation of the data, the participant's responses between 0 and 3 were given a 1 value which indicates low self-efficacy, responses between 4 and 6 were given the 2 value to indicate moderate self-efficacy, and the remaining responses of 7–9 were given the value of 3 to indicate high self-efficacy. The data indicated that participants who responded to the measures viewed themselves as having moderate to high levels of self-efficacy when conducting animal assisted play therapy sessions (M = 2.63, SD = .572 on the AAPT Self Efficacy measure and M = 2.53, SD = .514 on the CASES measure) (see Table 3).

Table 3

*Descriptive Statistics for Self-Efficacy Measures*

	N	Minimum	Maximum	M	SD
AAPT Self-Efficacy	67	2	3	2.63	.572
CASES	67	1	3	2.53	.514

**Research Question #2: Is there a statistical difference in self-reported counseling self-efficacy by years of counseling experience?**

To assess the potential self-efficacy difference related to the years of counseling experience, an analysis of variance (ANOVA) was performed on both self-efficacy measures. For this analysis, the years of counseling experience were broken down into three categories: 0–10 years (28.4%) of clinical experience, 11–20 years (19.4%), and 21 or more years (20.9%) of clinical experience as seen in Table 4.

Table 4

*ANOVA Results with Self-Efficacy Measures and Years of Clinical Experience*

Measure	df	F	$\eta$	Sig
AAPT Self-Efficacy	2	.397	.18	.675
CASES	2	2.383	.10	.104
CASES Insight Subscale	2	4.918	.186	.012*
CASES Exploration Subscale	2	4.642	.178	.015*
CASES Action Skills Subscale	2	1.578	.068	.218
CASES Session Management Subscale	2	4.72	.18	.014*
CASES Client Distress Subscale	2	.554	.025	.579
CASES Relationship Conflict Subscale	2	.513	.023	.602

Note. \* $p < .05$

The results of the ANOVA were not statistically significant on the AAPT self-efficacy questions or the CASES. Among the subscales of the CASES, years of counseling experience was statistically significant on the Insight Subscale  $F(2,43) = 4.92$ ,  $p = .012$ , Exploration Subscale  $F(2,43) = 4.64$ ,  $p = .015$  and Session Management Subscale  $F(2,43) = 4.724$ ,  $p = .014$ . Post hoc analyses using the Bonferonni post hoc criterion for significance indicated that the self-efficacy scores on the above mentioned subscales were significantly higher for participants with more than 21 years of experience when compared to participants with less than ten years of experience ( $p < .02$ ).



**Research Question #3: Is there a statistical difference in self-reported counseling self-efficacy by educational degree earned?**

An analysis of variance was conducted utilizing the participant’s level of degree which was re-categorized into master’s (71.6%) and post-master’s (22.4%) and compared on the two self-efficacy measures. The results of the ANOVA indicated that degree earned did not have a significant effect on the result of the self-reported counseling self-efficacy scores on the CASES or AAPT self-efficacy questions (see Table 5).

Table 5

*ANOVA with Self-Efficacy Measures and Highest Degree Earned*

Measure	df	F	$\eta$	Sig
AAPT Self-Efficacy	2	1.180	.007	.314
CASES	2	.174	.003	.678
CASES Insight Subscale	2	.781	.013	.38
CASES Exploration Subscale	2	.001	.00	.979
CASES Action Skills Subscale	2	.101	.002	.751
CASES Session Management Subscale	2	.000	.00	.997
CASES Client Distress Subscale	2	.444	.007	.508
CASES Relationship Conflict Subscale	2	.868	.14	.355

**Research Question #4: Is there a statistical difference in level of self-reported counseling self-efficacy by component of Animal-Assisted Play Therapy training?**

The participant’s responses were organized into three categories based on the component of training: online training only (7.5%), online and in-person training (34.3%), and in-person

training only (58.2%). The analysis of variance was conducted based on these three categories and compared on the scores of the two self-efficacy measures.

Table 6

*ANOVA with Self-Efficacy Measures and Component of AAPT Training*

Measure	df	F	$\eta$	Sig
AAPT Self-Efficacy	2	31.965	.5	.000***
CASES	2	5.701	.151	.005**
CASES Insight Subscale	2	5.239	.141	.008**
CASES Exploration Subscale	2	15.959	.333	.000***
CASES Action Skills Subscale	2	4.885	.132	.011*
CASES Session Management Subscale	2	7.146	.183	.002**
CASES Client Distress Subscale	2	1.154	.035	.322
CASES Relationship Conflict Subscale	2	1.029	.031	.363

Note: \* $p < .05$  \*\* $p < .01$  \*\*\* $p < .001$

The component of training showed statistically significance in the self-efficacy scores on the AAPT ( $p = .000$ ) measure, the overall CASES ( $p = .005$ ), and the following CASES subscales: Insight ( $p = .008$ ), Exploration ( $p = 0.00$ ), Action Skills ( $p = 0.011$ ), and Session Management ( $p = 0.02$ ). The Bonferroni post hoc indicated that the participants who did in-person training scored significantly higher on the self-efficacy measures than the participants who have participated in the online training only ( $p < .000$ ). Participants who engaged in online and face-to-face training did not show any statistical significance ( $p > .05$ ).

**Research Question # 5: Is there a statistical difference in level of self-reported counseling self-efficacy by play therapy credentials?**

A one-way analysis of variance was conducted comparing the scores of the AAPT self-efficacy measure and the CASES based on the participant variable of play therapy credentialing. Fifty-two percent (52%) of participants have a play therapy credential and 47.8% do not. Based on the AVOVA, the CASES subscales of Exploration and Session Management was statistical significant. The presence of a play therapy credential was not significant to the results of the other analyses. The results are displayed in Table 7.

Table 7

*ANOVA with Self-Efficacy Measures and Play Therapy Credentials*

Measure	df	F	$\eta$	Sig
AAPT Self-Efficacy	2	3.435	.050	.068
CASES	2	3.120	.046	.082
CASES Insight Subscale	2	3.517	.064	.065
CASES Exploration Subscale	2	4.466	.051	.038*
CASES Action Skills Subscale	2	.523	.008	.472
CASES Session Management Subscale	2	7.168	.099	.009**
CASES Client Distress Subscale	2	.666	.010	.418
CASES Relationship Conflict Subscale	2	.341	.005	.561

Note: \*p < .05 \*\*p < .01

## **Open-Ended Questions**

The open-ended questions from the online survey produced responses that were supportive of the quantitative measures. The responses were coded by hand using open-coding (Corbin & Strauss, 1990). The response frequencies were established by calculating the number of participants whose specific response fell into the theme.

The participants indicated that a majority were drawn to the AAPT training to acquire new knowledge, skills, and methods in implementing animal assisted play therapy. The participants reported that the training components were beneficial. Fifty eight responses indicated that they used AAPT during their own therapeutic process with a specific intervention, technique, or theoretical approach they learned in the training and specifically twelve of the participants indicated that they found using AAPT with clients experiencing anxiety, depression, and other cognitive related presenting concerns was most helpful while others reported that it was always helpful. Some of the challenges that the participants faced when using AAPT were commonly related to client's well-being such as fears, allergies, stress level, and the safety of both the client and dog. The importance of a safe place for the animal to go while not participating in AAPT as well as liability insurance was also commonly reported. The results of the open-ended questions are listed in Table 8 through 12.

Table 8

*Open-Ended Questions Frequencies: What drew you to AAPT training?*

Themes	Frequencies	Subcategories
Knowledge	35	Prior knowledge of animals, counseling, AAT or AAPT Desire to increase knowledge about AAPT, the use of animals in therapy / counseling
Experience	27	Prior experiences with Dr. Risë VanFleet Prior personal experience, thoughts, and feelings of animals Previous work experiences with animals or animal-assisted program
Incorporating Animals	14	Desire to incorporate own animal into their practice Desire to incorporate animals (no their own)
Beliefs	5	Prior beliefs about animals and AAPT

Table 9

*Open Ended Questions Frequencies: What is the most useful aspect of the AAPT training?*

Themes	Frequencies	Subcategories
Learning	38	New Methods, techniques or levels of awareness Active learning components Learning done outside of in-person training session Personal benefits outside of AAPT
Specific Training Components	37	Animal Communication, behavior and interaction with others Providing care and training to animals Conducting therapeutic sessions
Non specific	7	General comments (i.e. “All of it”, “Everything has been useful”, “Very thorough”)

Table 10

*Open-Ended Questions Frequencies: How do you use AAPT in the therapeutic process?*

Themes	Frequencies	Subcategories
Current Practice	12	Client choice Frequency of application of AAPT
Purpose and/or Benefits	6	Comfort and goal attainment
Counseling Skills or Technique	29	Specific type of interventions (i.e. Directive, Non-directive or Rapport-building)
Specific client populations	11	Anxiety Autism Impulsive Adopted
Not Currently Practicing	16	In school Still being trained Not allowed in current work setting

Table 11

*Open-Ended Questions Frequencies: In what situations do you find AAPT most beneficial?*

Themes	Frequencies	Subcategories
Specific psychological concerns	14	AAPT with client who present with specific psychological concerns such as anxiety, self-esteem and depression
Social Skills	8	AAPT with client's expressing social & behavioral concerns (i.e. Rapport Building, Socialization, & Empathy)
Trauma Experience	9	Client's with traumatic experiences including abuse and PTSD
Autism Spectrum	4	Responses that mention Autism
Speculations	4	I perceive... I think it could... I assume...
General	25	Always helpful Numerous Every client Equally beneficial



Table 12

*Open-Ended Questions Frequencies: What challenges have you faced when using AAPT?*

Themes	Frequencies	Subcategories
Safe Place	7	Need for a safe place for the dog to go when not in session
Scheduling	6	Time management, ensuring the animal gets breaks
Clients	33	Challenges working with animals and clients together such as allergies, fears and the dislike of the animal
Maintenance of knowledge base	5	Time to train Personal confidence levels
Minimal or No Challenges	4	Responses that include NA or minimal Recently started with animal
Other	15	Liability insurance Work site limitations No animal or picking animal

## CHAPTER V. DISCUSSION

### **Introduction**

The purpose of this study was to examine the level of perceived counselor self-efficacy among counselors who were trained in Animal-Assisted Play Therapy (AAPT). In addition, the investigator intended to investigate at the relationship between self-efficacy and years of counseling experience, highest degree earned, component of AAPT training completed, and the presence of a play therapy (PT) credential. These topics were arranged into five research questions that guided the investigation in the study.

The methods used for this survey study included quantitative data collection as well as short-answer responses. The participant pool was made up of all females whose ages ranged from 25–67 with the mean age of 51.92. The participants varied in education level (master's 71.6% and post masters 22.4%), years of counseling experience (0–10 = 28.4%, 11–20 = 19.4%, 21 or more = 20.9%), and component of AAPT training (online only = 7.5%, online and in-person = 34.3%, and in-person only = 58.2%). Some of the participants had obtained a PT certification (52.2%), and some had not (47.8%). The participant responses were collected through an online survey site. The survey link was distributed by the Playful Pooch trainer (Dr. R. VanFleet). The survey included demographic questions, AAPT Self-Efficacy measure, the Counselor Activity Self-Efficacy Scale (CASES), and five short-answer questions. The data was analyzed using a one-way analysis of variance (ANOVA). In this final chapter, the findings and

limitations of the study will be discussed, implications for the AAPT training will be explored, and recommendations for future research will be presented.

### **Discussion**

This study indicates that self-reported counseling self-efficacy in performing Animal Assisted Play Therapy is at the moderate to high level for participants who went through the Playful Pooch AAPT program. Due to the nature of the research design in which no control group was set for comparison, it could not be asserted that the results were purely impacted by the training; however, all participants with training at the organization gained confidence in conducting AAPT. Larson and Daniels (1998) found that higher counselor-self-efficacy was positively correlated with counselor performance.

The study results indicated that years of counseling experience could have an effect on counselor self-efficacy among AAPT practitioners. There were statistically significant differences in the participant's scores of three CASES subscales when analyzed by the years of clinical experience. Specifically, participants with more than 21 years of experience scored higher than participants with less than ten years of experience. This may indicate that extensive counseling experience can help with gaining confidence in certain domains faster than others when AAPT training is provided. Such confidence building was reported in the three subscales of Insight, Exploration, and Session Management. These results are congruent with results from the Larson and colleagues (1992) study where they examined differences in self-efficacy based on years of counseling experience and education level. Their results indicated that, as experience and training increase, so does self-efficacy. It may be worth noting that two (Insight and Session Management) of the three subscales were in measuring advanced counseling skills. In other words, AAPT training may assist with confidence building among seasoned counselors in

advanced counseling skills domains as well as in basic counseling skills domains by showing higher confidence compared to less experienced counselors. The CASES subscales of Insight measured the participant's competencies of "challenging client inconsistencies, offering interpretations, and using self-involving immediacy statements" (Lent, Hill & Hoffman, 2003, p. 101). The Session Management subscale measured the perceived competence to facilitate the process of counseling sessions. The subscale of Exploration included basic counseling skills such as restatements, reflecting feelings, and attending skills. Melchert and colleagues (1996) were interested in whether Bandura's self-efficacy theory predicts the participant's level of self-efficacy based on experience and training. Their results indicated that 43% of variance was attributed to years of experience and level of training. This study and the Melchert and colleagues' study also aligns with Martin, Easton, Wilson, Takemoto & Sullivan (2004), which resulted in 33% variability in counselor self-efficacy explained by level of experience.

Educational degree is an important factor in the counseling field as well as a requirement to participate in the Playful Pooch training program, but the result of this study did not indicate that it had a significant impact on the self-reported counseling self-efficacy when conducting the animal assisted play therapy session. A study by Johnson and colleagues (1989) investigated counseling self-efficacy and training. Specifically, they were looking at graduate level counseling courses. They found that the participant's self-efficacy levels increased significantly over time. However, when it comes to specific areas of practice such as AAPT, the difference between the two degree levels does not have meaningful value. As it relates to a specific domain of counseling practice it looks like specialized training in the area is important in developing self-efficacy.

This study found that the component of Playful Pooch training made a difference in the self-efficacy among the participants. Particularly, participants who had completed the in-person training showed higher scores on the AAPT self-efficacy measure, the CASES, and a majority of the subscales. This may indicate that, although the outside reading and online components are a requirement for the current certification, the live skills building training component results in the biggest difference in self-reported counseling self-efficacy levels. These results support Bandura's theory that self-efficacy develops as experiential training increase so does a person's confidence in their professional abilities (Bandura, 1986b). The results of the quantitative measures were supported by the participant's responses to the open ended questions. When asked what the most useful aspect of the AAPT training was, 38 of the responses mentioned learning new information, and 37 related to a specific component of the training.

The analysis of that included the play therapy credentials did not result in a statistically significant variance in counselor self-efficacy in this study except for in the CASES the exploration and session management subscales. The generalized requirements of the credential may not support the development of skills in the specialized area of AAPT. Play therapist on the other hand do participate in specialized courses, clinical experiences and supervision which may support their perceived capability to conduct the counseling session which is measure on the session management subscale. As for the explorations subscale, it includes basic counseling skills such as attending, using restatements and reflecting feelings. These are key components to the play therapy approach and which have resulted in the statistically significant variance in this study.

In summary, based on the findings of the current study it can be concluded as follows. First, overall counselors who completed the AAPT training through Playful Pooch felt moderate

to high counseling self-efficacy when conducting animal assisted play therapy sessions. Second, this moderate to high self-efficacy is mostly related to in-person training that they received through Playful Pooch as well as extended years of counseling experience. Education level (either masters or post masters) along with the play therapy credentials did not show any relationship with levels of self-efficacy among the current research participants.

### **Limitations of the Study**

Several limitations should be taken into consideration when interpreting the results and planning for future research. The first limitation was the use of measures requiring self-report. The measures used for this study required counselors trained in AAPT to respond based on their self-assessments of their ability to complete AAPT tasks, use helping skills effectively when conducting AAPT session, and their confidence level when working effectively with specific clientele. It should be noted that the level reported by the counselors does not refer to their actual clientele outcome but only to their self-perceived efficacy levels related to conducting the AAPT session. As a result of the participants' ability to self-report, they may have presented themselves in a more favorable manner or in a manner that is more socially desirable. In the future, it would be beneficial for future research to be conducted that includes self-report measures and outcome data.

The second limitation of this study focuses on instruments used to measure self-efficacy of the participants. This measure was normed using 345 students (Lent, Hill, & Hoffman, 2003), and the questions were originally formatted for general counseling sessions. For this study, the instrument was modified by the primary investigator with the permission of the original author (Lent, 2013, personal email correspondence). The modifications allowed the investigator to base the participant's responses specifically on conducting AAPT sessions. Although the primary

investigator provided a definition of AAPT to the participants prior to them responding to the measure, it cannot be guaranteed that all participants responded to the questions appropriately. The primary investigator included questions specific to AAPT self-efficacy in order to compensate for the lack of specificity in the original measure.

The third limitation to this study was survey items that were included in the instruments. In this study, the primary work setting of the participants was with children. Although, the instruments used did not include tasks and skills specific to working with children, the results should be interpreted in cause when it related to AAPT counselors working with adults only.

The final limitation to this study involves the sample population. Participants were solicited for this study by the Playful Pooch trainer. Dr. VanFleet has trained approximately 300 students since 2007. For this study, the participants were recruited primarily through Facebook and email. Seventy-nine (79) participants visited the online survey, of which 67 participant's responses were used for analysis. This small sample size, as well as the recruitment from only one training program, resulted in a validity concern. In order to decrease the threat to external validity, it is encouraged that future research includes other AAPT training programs and a larger participant pool. The current study will lay the groundwork for future undertakings.

### **Implications**

The results indicated that moderate to high levels of counselor self-efficacy could be experienced by participants in the Playful Pooch AAPT training. Counselors who choose to utilize AAPT in their therapeutic setting may be recommended to receive AAPT training in order to increase their counselor self-efficacy levels. Counseling experience can affect counselor self-efficacy when performing AAPT. The study results were statistically significant on the Insight, Exploration, and Session Management subscales. Based on this result, participants interested in

AAPT may want to have post masters clinical experience prior to attending the in-person AAPT training. Post-master's training in the specific area of AAPT is supported and may be more important than obtaining a higher academic degree. The specialty training includes components that are supportive of counselor self-efficacy development. The specificity of these components is not obtained during masters and post masters academic experiences. Knowledge and skills that are obtained through the play therapy credentialing process may be transferrable in managing sessions of AAPT. However, it may not be necessary to obtain the play therapy credential in order to obtain the AAPT training. Overall, the best way to obtain counselor self-efficacy when conducting an AAPT session is to receive the specific AAPT training in person. More programs may need to be developed in order to meet the needs of counselors who wish to receive this training.

Though there are limitations to this study, it does offer a foundation for future outcome research utilizing counselors trained in animal-assisted therapy. The results of this study support the importance of continued AAPT training for those counselors who wish to conduct animal assisted play therapy sessions with their clients.

### **Recommendations for Future Research**

As mental health issues continue to affect children, it is important that counselors feel effective in their counseling skills and the specific modalities that they adopt. The AAPT approach is a newer modality; therefore, there are various avenues for future research. Again, future research should attend to the limitations of the present study. This study focused on the levels of self-efficacy of counselors who received AAPT training in performing AAPT and on the demographic variable that might affect the levels. Given that the sample size for this study is relatively small to produce a high effect size, future research may duplicate this study with larger



populations. It is not always true to assume that high self-efficacy is positively correlated with high performance; therefore, outcome research needs to be performed along with the self-efficacy survey study.

Animal-Assisted Play Therapy is most commonly used when working with children (VanFleet, 2008b) versus the adult population. Nevertheless, the measures used in the current study were not specifically measuring counselor self-efficacy in working with children. As such, future research may need to include the development of an instrument to assess children's counselors' self-efficacy levels. This will allow for future research to be specifically focused on children's counselors' self-efficacy, thus producing results that are more generalized to working with children.

A longitudinal case study following participants through the various levels of AAPT training would be beneficial in evaluating step by step training effect on counselor's self-efficacy building. This information will be able to help training institutions continuously improve training curriculum and methods for better training.

### **Conclusion**

Overall, the results of the current study serve as evidence that appropriate training in AAPT does affect a counselor's level of self-efficacy to conduct sessions. Because AAPT is in the beginning stages of verification and implementation, there is a paucity of research. This study hopes to add to the literature and lay the groundwork for future research endeavors.

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## Appendix 1

### Permission to Modify Instrument Used in Study

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**Kori Hansing** <korihansing@gmail.com>  
To: "Robert W. Lent" <boblent@umd.edu>

Sun, Oct 13, 2013 at 9:24 AM

Thank you Dr. Lent.

When putting your measure into the online format I would like you permission to use Animal Assisted Play Therapy in place of the words "counseling", "with most clients", "in counseling most clients", "work" (Part III).

Enjoy you day!

Kori Hansing

Kori Hansing

Doctoral Candidate-Auburn University  
Children's Therapist- CARES Program- Family Sunshine Center  
Adjunct Professor- Alabama State University  
941-345-7623

You can discover more about a person in an hour of play than in a year of conversation. ~Plato

The only person who is educated is the one who has learned how to learn and change. ~Carl Rogers

[Quoted text hidden]

---

**Robert W. Lent** <boblent@umd.edu>  
To: Kori Hansing <korihansing@gmail.com>

Sun, Oct 13, 2013 at 9:50 AM

Permission granted. Of course, the measure was not designed for that purpose, so the burden of proof would be on you to demonstrate adequate psychometric characteristics in that context.

Dr. Lent

**From:** Kori Hansing [mailto:korihansing@gmail.com]  
**Sent:** Sunday, October 13, 2013 10:24 AM  
**To:** Robert W. Lent  
**Subject:** Re: Dissertation- Counselor Activity Self Efficacy Scale



Kori Hansing <korihansing@gmail.com>

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**CASES modification**

5 messages

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**Kori Hansing** <korihansing@gmail.com>  
To: Bob Lent <boblent@umd.edu>

Tue, Dec 3, 2013 at 1:56 PM

Good Afternoon Dr. Lent,

I have met with my dissertation committee and I would like you permission to add a "Not Applicable" option to Part III of the CASES.

I look forward to your response.

Kori Hansing, MA, ALC

Doctoral Candidate-Auburn University  
Children's Therapist- CARES Program- Family Sunshine Center  
Adjunct Professor- Alabama State University  
work: 334-206-2142, cell: 941-345-7623

You can discover more about a person in an hour of play than in a year of conversation. ~Plato

The only person who is educated is the one who has learned how to learn and change. ~Carl Rogers

---

**Robert W. Lent** <boblent@umd.edu>  
To: Kori Hansing <korihansing@gmail.com>

Tue, Dec 3, 2013 at 2:08 PM

Adapt it as you wish, just make sure to specify any modifications in your dissertation or research article.

Dr. Lent

**From:** Kori Hansing [mailto:korihansing@gmail.com]  
**Sent:** Tuesday, December 03, 2013 2:56 PM  
**To:** Robert W. Lent  
**Subject:** CASES modification

[Quoted text hidden]

---

**Kori Hansing** <korihansing@gmail.com>  
To: "Robert W. Lent" <boblent@umd.edu>

Tue, Dec 3, 2013 at 2:09 PM

Thank you and I will make sure to do so.

## Appendix 2

Auburn University Institutional Review Board (IRB) Approval



**AUBURN UNIVERSITY INSTITUTIONAL REVIEW BOARD for RESEARCH INVOLVING HUMAN SUBJECTS  
RESEARCH PROTOCOL REVIEW FORM**

For Information or help contact **THE OFFICE OF RESEARCH COMPLIANCE**, 115 Ramsay Hall, Auburn University  
Phone: 334-844-5966 e-mail: [hsubject@auburn.edu](mailto:hsubject@auburn.edu) Web Address: <http://www.auburn.edu/research/vpr/ohs/>

Revised 03.26.11 – DO NOT STAPLE, CLIP TOGETHER ONLY.

Save a Copy

1. PROPOSED START DATE of STUDY: Feb 10, 2014

PROPOSED REVIEW CATEGORY (Check one):      FULL BOARD      EXPEDITED       EXEMPT

2. PROJECT TITLE: Self-Efficacy among Counselors Trained in Animal Assisted Play Therapy

3. Karin K. Hansing PRINCIPAL INVESTIGATOR	TITLE	SERC DEPT	(334) 844-7676 PHONE	kkh0006@tigermail.auburn.edu AU E-MAIL
2084 Haley Center Auburn, AL 36849 MAILING ADDRESS	Phone:	(334) 844-7677 FAX	suhshy@auburn.edu ALTERNATE E-MAIL	

4. SOURCE OF FUNDING SUPPORT:  Not Applicable     Internal     External Agency: \_\_\_\_\_     Pending     Received

5. LIST ANY CONTRACTORS, SUB-CONTRACTORS, OTHER ENTITIES OR IRBs ASSOCIATED WITH THIS PROJECT:

6. GENERAL RESEARCH PROJECT CHARACTERISTICS

6A. Mandatory CITI Training		6B. Research Methodology	
Names of key personnel who have completed CITI: Karin K Hansing      Suhyun Suh <hr/> <hr/> <hr/> CITI group completed for this study: <input checked="" type="checkbox"/> Social/Behavioral <input type="checkbox"/> Biomedical		Please check all descriptors that best apply to the research methodology. Data Source(s): <input checked="" type="checkbox"/> New Data <input type="checkbox"/> Existing Data Will recorded data directly or indirectly identify participants? Yes <input checked="" type="checkbox"/> No Data collection will involve the use of: <input type="checkbox"/> Educational Tests (cognitive diagnostic, aptitude, etc.) <input type="checkbox"/> Interview / Observation <input type="checkbox"/> Physical / Physiological Measures or Specimens (see Section 6E) <input checked="" type="checkbox"/> Surveys / Questionnaires <input checked="" type="checkbox"/> Internet / Electronic <input type="checkbox"/> Audio / Video / Photos <input type="checkbox"/> Private records or files	
PLEASE ATTACH TO HARD COPY ALL CITI CERTIFICATES FOR EACH KEY PERSONNEL		The Auburn University Institutional Review Board has approved this document for use from 2/5/14 to 2/4/15 Protocol # 14-043 EP1462	
6C. Participant Information		6D. Risks to Participants	
Please check all descriptors that apply to the participant population. <input checked="" type="checkbox"/> Males <input checked="" type="checkbox"/> Females <input type="checkbox"/> AU students <b>Vulnerable Populations</b> <input type="checkbox"/> Pregnant Women/Fetuses <input type="checkbox"/> Prisoners <input type="checkbox"/> Children and/or Adolescents (under age 19 in AL) <b>Persons with:</b> <input type="checkbox"/> Economic Disadvantages <input type="checkbox"/> Physical Disabilities <input type="checkbox"/> Educational Disadvantages <input type="checkbox"/> Intellectual Disabilities Do you plan to compensate your participants? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Please identify all risks that participants might encounter in this research. <input type="checkbox"/> Breach of Confidentiality* <input type="checkbox"/> Coercion <input type="checkbox"/> Deception <input type="checkbox"/> Physical <input checked="" type="checkbox"/> Psychological <input type="checkbox"/> Social <input type="checkbox"/> None <input type="checkbox"/> Other: The participants may encounter discomforts when completing the survey questionnaire. The participants will reflect on their own experiences in counseling individuals and their own subjective accounts of their self-esteem regarding their counseling efficacy. *Note that if the investigator is using or accessing confidential or identifiable data, breach of confidentiality is always a risk.	
Do you need IBC Approval for this study? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - BUA # _____    Expiration date _____			

FOR OHSR OFFICE USE ONLY

DATE RECEIVED IN OHSR: _____ by _____	PROTOCOL # <u>14-043</u>
DATE OF IRB REVIEW: _____ by _____	APPROVAL CATEGORY: _____
DATE OF IRB APPROVAL: _____ by _____	INTERVAL FOR CONTINUING REVIEW: _____
COMMENTS:	

**7. PROJECT ASSURANCES**

**PROJECT TITLE:** Self-Efficacy among Counselors Trained in Animal Assisted Play Therapy

**A. PRINCIPAL INVESTIGATOR'S ASSURANCES**

1. I certify that all information provided in this application is complete and correct.
2. I understand that, as Principal Investigator, I have ultimate responsibility for the conduct of this study, the ethical performance this project, the protection of the rights and welfare of human subjects, and strict adherence to any stipulations imposed by the Auburn University IRB.
3. I certify that all individuals involved with the conduct of this project are qualified to carry out their specified roles and responsibilities and are in compliance with Auburn University policies regarding the collection and analysis of the research data.
4. I agree to comply with all Auburn policies and procedures, as well as with all applicable federal, state, and local laws regarding the protection of human subjects, including, but not limited to the following:
  - a. Conducting the project by qualified personnel according to the approved protocol
  - b. Implementing no changes in the approved protocol or consent form without prior approval from the Office of Human Subjects Research
  - c. Obtaining the legally effective informed consent from each participant or their legally responsible representative prior to their participation in this project using only the currently approved, stamped consent form
  - d. Promptly reporting significant adverse events and/or effects to the Office of Human Subjects Research in writing within 5 working days of the occurrence.
5. If I will be unavailable to direct this research personally, I will arrange for a co-investigator to assume direct responsibility in my absence. This person has been named as co-investigator in this application, or I will advise OHSR, by letter, in advance of such arrangements.
6. I agree to conduct this study only during the period approved by the Auburn University IRB.
7. I will prepare and submit a renewal request and supply all supporting documents to the Office of Human Subjects Research before the approval period has expired if it is necessary to continue the research project beyond the time period approved by the Auburn University IRB.
8. I will prepare and submit a final report upon completion of this research project.

My signature indicates that I have read, understand and agree to conduct this research project in accordance with the assurances listed above.

Karin K Hansing

Printed name of Principal Investigator

  
Principal Investigator's Signature  
(SIGN IN BLUE INK ONLY)


2/1/14  
Date

**B. FACULTY ADVISOR/SPONSOR'S ASSURANCES**

1. By my signature as faculty advisor/sponsor on this research application, I certify that the student or guest investigator is knowledgeable about the regulations and policies governing research with human subjects and has sufficient training and experience to conduct this particular study in accord with the approved protocol.
2. I certify that the project will be performed by qualified personnel according to the approved protocol using conventional or experimental methodology.
3. I agree to meet with the investigator on a regular basis to monitor study progress.
4. Should problems arise during the course of the study, I agree to be available, personally, to supervise the investigator in solving them.
5. I assure that the investigator will promptly report significant adverse events and/or effects to the OHSR in writing within 5 working days of the occurrence.
6. If I will be unavailable, I will arrange for an alternate faculty sponsor to assume responsibility during my absence, and I will advise the OHSR by letter of such arrangements. If the investigator is unable to fulfill requirements for submission of renewals, modifications or the final report, I will assume that responsibility.
7. I have read the protocol submitted for this project for content, clarity, and methodology.

Dr. Suhyun Suh

Printed name of Faculty Advisor / Sponsor

  
Signature (SIGN IN BLUE INK ONLY)

2/1/14  
Date

**C. DEPARTMENT HEAD'S ASSURANCE**

By my signature as department head, I certify that I will cooperate with the administration in the application and enforcement of all Auburn University policies and procedures, as well as all applicable federal, state, and local laws regarding the protection and ethical treatment of human participants by researchers in my department.

Dr. E. Davis Martin Jr.

Printed name of Department Head

  
Signature (SIGN IN BLUE INK ONLY)

2/3/2014  
Date

## Appendix 3

### Permission to Use the CASES Measure



Kori Hansing <korihansing@gmail.com>

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**Dissertation- Counselor Activity Self Efficacy Scale**

6 messages

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**Kori Hansing** <korihansing@gmail.com>  
To: boblent@umd.edu

Sun, Sep 29, 2013 at 4:42 PM

My name is Kori Hansing, and I am a doctoral candidate at Auburn University. I would like to obtain your permission to use this inventory for my study. I am looking at the self-efficacy levels of Animal Assisted Play Therapists. I have used your scale with a research team here at Auburn that traveled to South Korea in May.

I look forward to hearing back from you!

Kori Hansing

Doctoral Candidate-Auburn University  
Children's Therapist- CARES Program- Family Sunshine Center  
Adjunct Professor- Alabama State University  
[941-345-7623](tel:941-345-7623)

You can discover more about a person in an hour of play than in a year of conversation. ~Plato

The only person who is educated is the one who has learned how to learn and change. ~Carl Rogers

---

**Robert W. Lent** <boblent@umd.edu>  
To: Kori Hansing <korihansing@gmail.com>

Sun, Sep 29, 2013 at 4:49 PM

You are welcomed to use the CASES in your study.

Best wishes,

Dr. Lent

**From:** Kori Hansing [mailto:korihansing@gmail.com]  
**Sent:** Sunday, September 29, 2013 5:43 PM  
**To:** Robert W. Lent  
**Subject:** Dissertation- Counselor Activity Self Efficacy Scale

[Quoted text hidden]

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**2 attachments**

## Appendix 4

### Willingness to Distribute Survey



Kori Hansing <korihansing@gmail.com>

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**willingness to distribute**

1 message

---

**Dr. Rise VanFleet** <rise@risevanfleet.com>  
To: kkh0006@tigermail.auburn.edu

Mon, Nov 4, 2013 at 10:11 AM

Hello Kori,

This email confirms what we covered in our phone conversation. I am very willing to distribute your dissertation survey link to those who have attended past training programs I've conducted, as well as on my Facebook group pages where people with a wide range of AAT or AAPT training and experience are quite active. People will be able to voluntarily participate or not, and at no time will I need to provide you with identifying information about those to whom I've distributed it.

Please let me know if you need anything else from me at this time!

Risë

--

Risë VanFleet, PhD, RPT-S, CDBC  
[www.risevanfleet.com](http://www.risevanfleet.com)

Playful Pooch Program  
Family Enhancement & Play Therapy Center  
PO Box 613, Boiling Springs, PA 17007 USA  
717-249-4707

Appendix 5  
Informed Consent

**Default Question Block**

Informed Consent  
For a Research Study Entitled

"Self-Efficacy among Counselors Trained in Animal Assisted Play Therapy"

You are invited to participate in a research study to assess counselor self-efficacy when conducting an Animal Assisted Play Therapy session. This study will examine the self-reported self-efficacy levels of participants who represent various training backgrounds. As such, the researcher will investigate the relationship between counselor self-efficacy scores and the following variables: (a) years of clinical experience, (b) education level of the participant, (c) Play Therapy credentials, and (d) the level of Animal Assisted Play Therapy training. This study is being conducted by Karin K. Hansing, MA, under the direction of Suhyun Suh, Ed.D in the Auburn University Department of Special Education, Rehabilitation and Counseling. You were selected as a possible participant because you have participated in Animal Assisted Play Therapy Training and are age 19 or older.

Your participation is completely voluntary. If you decide to participate in this research study, you will be asked to complete an anonymous online survey. Your total time commitment will be approximately 15-20 minutes.

The risks associated with participating in this study are minimal but may include: discomfort when completing the survey questionnaire and / or stress related to inward reflection. However, should taking this survey result in any distress or you change your mind about participating, you may withdraw at any time (example: closing your browser window). Additionally, at the end of the study referral information will be provided if you feel the need to discuss your distress.

If you change your mind about participating, you can withdraw at any time during the study. Once you've submitted anonymous data, it cannot be withdrawn since it will be unidentifiable. The data will be in an aggregated form so that no individual can be identified.

As an incentive to complete the survey, the researcher will be donating \$1.00 for every complete response to the American Humane Association. The donation will aid in their efforts to "ensure the welfare, wellness and well-being of children and animals, and to unleash the full potential of the bond between humans and animals to the mutual benefit of both" (American Humane Association, 2013).

Information obtained through your participation may be used to fulfill an educational requirement, and/or for conference/research presentations and publications.

If you have questions about this study, please contact Karin K. Hansing by email at kkh0006@tigermail.auburn.edu or Dr. Suhyun Suh at suhsuh@auburn.edu. You are welcome to print this document for your personal records.

If you have questions about your rights as a research participant you may contact the Auburn University Office of Human Subjects Research or the Institutional Review board by phone 334-844-5966 or email at hsubjec@auburn.edu or IRBChair@auburn.edu.

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE WHETHER OR NOT YOU WISH TO PARTICIPATE IN THIS RESEARCH STUDY. BY CLICKING "I AGREE" BELOW INDICATES YOUR WILLINGNESS TO PARTICIPATE.

Are you over the age of 19 and wish to participate in this research study?

- I AGREE
- I DISAGREE

Have you participated in Animal Assisted Play Therapy Training through the Playful Pooch Program?

- Yes
- No

**Demographic Questions**

For the following questions please fill in the blank.

What gender do you identify with?

---



What is your age?

What ethnicity / race do you identify with?

What is the highest degree or level of education you have completed? If currently enrolled, highest degree received.

- High school graduate, diploma or the equivalent (for example: GED)
- Some college credit, no degree
- Trade/technical/vocational training
- Associate degree
- Bachelor's degree
- Master's degree
- Professional degree
- Doctorate degree

What type of degree program did you graduate from?

- Clinical Mental Health Counseling
- School Counseling
- Marriage, Couple and Family Counseling
- Career Counseling
- Student affairs and College Counseling
- Rehabilitation Counseling
- Counselor Education
- School Psychology
- Counseling Psychology
- Clinical Psychology
- Other (please specify)

How many years of clinical experience do you have?

What professional certification(s) or license(s) do you hold? (check all that apply)

- Working towards state license
- National Certified Counselor
- Licensed Psychologist
- Licensed Social Worker
- Licensed Mental Health Counselor / Licensed Professional Counselor (or equivalent)
- Licensed Marriage and Family Counselor
- Licensed Alcohol and Drug Counselor (or equivalent)
- Certified School Counselor
- Registered Play Therapist (APT)
- Registered Play Therapist Supervisor (APT)
- Qualified Play Therapist (BAPT)

- Certified Play Therapist (CACPT)
- None
- Other (please specify)  
\_\_\_\_\_

Please indicate which of the following describes your current clinical setting.

- Play therapy with animal assistance
- Play Therapy without animal assistance
- Animal Assisted Therapy without play
- Children's therapy without play or animals
- Adult therapy without animals
- Adult therapy with animals
- Other  
\_\_\_\_\_

What country do you practice in?

\_\_\_\_\_

How much Play Therapy training have you had? (choose all that apply)

- None
- Continuing education / Conference Sessions
- Graduate Coursework
- less than 20 hours
- more than 20 hours

In what year was your most recent Play Therapy training?

\_\_\_\_\_

How much Animal Assisted Play Therapy training have you participated in? (choose all that apply)

- Continuing education / Conference session
- Graduate coursework
- Online Courses- through Playful Pooch
- Animal Assisted Play Therapy 1- through Playful Pooch
- Animal Assisted Play Therapy 2- through Playful Pooch
- Supervised Practice- through Playful Pooch
- Other (please specify)  
\_\_\_\_\_

In what year was your most recent Animal Assisted Play Therapy training?

\_\_\_\_\_

### Self-Efficacy Questions

For the purpose this study, the researcher is utilizing the following definition of Animal-Assisted Play Therapy.

*Animal-assisted Play Therapy (AAPT)* is defined as the use of animals in the context of play therapy, in which appropriately trained therapists and animals engage with children and families, primarily through systematic play interventions, with the goal of improving children's developmental and psychosocial health, as well as the animals' well-being. (VanFleet, 2007 p. 17)

Instructions: Please indicate by clicking the circle below the number that best reflects how confident you are in your ability to complete each of the following **Animal-assisted play therapy** task effectively.

	No confidence 0	1	2	3	4	Some confidence 5	6	7	8	Complete Confidence 9
1. Select appropriate animal for use in therapeutic session	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Appropriately socialize an animal selected for use in a therapeutic session	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Carry out appropriate and positive training and preparation of a selected animal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Demonstrate competence in reading and responding to animal body language in real time	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Demonstrate competence in reading and responding to human body language in real time	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Demonstrate the ability to focus on the well-being of the client and animal assistant at the same time	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Use humor / playfulness appropriately to facilitate therapeutic processes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**General Instructions**

The following questionnaire consists of three parts. Each part asks your beliefs about your ability to perform various counselor behaviors or to deal with or particular issues in counseling. Please provide your honest, candid responses that reflect your beliefs about your current capabilities, rather than how you would like to be seen or how you might look in the future. There is no right or wrong answers to the following questions. Please indicate by clicking the circle below the number that best reflects your response to each question.

**Part I.**

Instructions: Please indicate how confident you are in your ability to use each of the following helping skills effectively when conducting **animal assisted play therapy sessions**.

	No confidence 0	1	2	3	4	Some confidence 5	6	7	8	Complete confidence 9
1. <b>Attending</b> (orient yourself physically toward the client).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. <b>Listening</b> (capture and understand the messages clients communicate).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. <b>Restatements</b> (repeat or rephrase what the client has said, in a way that is succinct, concrete, and clear).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. <b>Open questions</b> (ask questions that help clients to clarify or explore their thoughts or feelings).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. <b>Reflection of feelings</b> (repeat or rephrase the client's statements with an emphasis on his or her feelings).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. <b>Self-disclosure for exploration</b> (reveal personal information about your history, credentials, or feelings).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. <b>Intentional silence</b> (use silence to allow clients to get in touch with their thoughts or feelings).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. <b>Challenges</b> (point out discrepancies, contradictions, defenses, or irrational beliefs of which the client is unaware or that he or she is unwilling or unable to change).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. <b>Interpretations</b> (make statements that go beyond what the client has overtly stated and that give the client a new way of seeing his or her behavior, thoughts, or feelings).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. <b>Self-Disclosure for insight</b> (disclose past experience in which you gained some personal insight).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. <b>Immediacy</b> (disclose immediate feelings you have about the client, the therapeutic relationship, or yourself in relation to the client).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. <b>Information-giving</b> (teach or provide the client with data, opinions, facts, resources, or answers to questions).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. <b>Direct guidance</b> (give the client suggestions, directives, or advice, that imply actions for the client to take).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. <b>Role play and behavior rehearsal</b> (assist the client to role-play or rehearse behaviors in-session).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Part II.**

**Instructions:** Please indicate how confident you are in your ability to do each of the following tasks effectively when conducting **animal assisted play therapy sessions**

	No confidence 0	1	2	3	4	Some confidence 5	6	7	8	Complete confidence 9
1. Keep sessions "on track" and focused.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Respond with the best helping skill, depending on what your client needs at a given moment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Help your client to explore his or her thoughts, feelings, and actions.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Help your client to increase awareness about his or her concerns at a "deep" level.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Know what to do or say next after your client talks.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Help your client's parents to set realistic counseling goals.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Help your client to understand his or her thoughts, feelings, and actions.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Build a clear conceptualization of your client and his or her counseling issues.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Remain aware of your intentions (i.e., the purposes of your interventions) during sessions.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Help your client to decide what actions to take regarding his or her problems.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Part III.**

**Instructions:** Please indicate how confident you are in your ability to work effectively, when conducting animal-assisted play therapy sessions, with each of the following client types, issues, or scenarios. (By "work effectively," we are referring to your ability to develop successful treatment plans, to come up with polished in-session responses, to maintain your poise during difficult interactions and, ultimately, to help the client to resolve his or her issues.)

How confident are you that you could work effectively with a client who ...

	No confidence 0	1	2	3	Some confidence 5	6	7	8	Complete confidence 9	Not Applicable
1. ... is clinically depressed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. ... has been sexually abused.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. ... is suicidal.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. ... has experienced a recent traumatic life event	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

(e.g., physical or psychological injury or abuse).

5. ... is extremely anxious.	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
6. ... shows signs of severely disturbed thinking.	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
7. ...you find sexually attractive.	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
8. ... is dealing with issues that you personally find difficult to handle.	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
9. ... has core values or beliefs that conflict with your own (e.g., regarding religion, gender roles).	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
10. ... differs from you in a major way or ways (e.g., race, ethnicity, gender, age, social class).	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
11. ...is not "psychologically minded" or introspective	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
12. ... is sexually attracted to you.	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
13. ... you have negative reactions toward (e.g., boredom, annoyance).	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
14. ... is at an impasse in therapy.	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
15. ... wants more from you than you are willing to give (e.g., in terms of frequency of contacts or problem-solving prescriptions).	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
16. ... demonstrates manipulative behaviors in-session.	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺

### Open Ended Questions

The final section contains 5 open-ended questions. Please type your response to the question in the corresponding box below. Thorough responses are greatly appreciated.

What drew you to attend Animal Assisted Play Therapy training?

What was the most useful aspect of the Animal Assisted Play Therapy training?

How do you use Animal Assisted Play Therapy in the therapeutic process?

In what situations do you find Animal Assisted Play Therapy to be most beneficial?

What challenges have you faced when using Animal Assisted Play Therapy?

Participant,

Thank you for completing this survey. During this survey, you were asked to complete multiple questionnaires. You were told that the purpose was to study counselor self-efficacy and this was in fact the actual purpose of this study.

If you have any concerns about your participation or the data you provided, please discuss this with us. We will be happy to provide any information we can to help answer questions you have about this study.

If your concerns are such that you would like your data withdrawn, you can close your browser window at this time. However, if your data is submitted, it is likely that there will be no way to identify your responses for removal due to the anonymous nature.

If you have questions about your participation in the study, please contact Karin K. Hansing by email at kkh0006@tigermail.auburn.edu or Dr.

Suhyun Suh at [suhsuhy@auburn.edu](mailto:suhsuhy@auburn.edu)

If you have questions about your rights as a research participant, you may contact the Office of Human Subject Research (334-844-5966, [hsubject@auburn.edu](mailto:hsubject@auburn.edu)) or Auburn University's Institutional Review Board ([IRBChair@auburn.edu](mailto:IRBChair@auburn.edu)).

Thank you for taking your time to complete this survey!

\$1.00 will be donated to the American Humane Association.



We're sorry, but at this time you do not meet the qualifications for this survey.  
We sincerely thank you and appreciate your time and dedication to the field.

## Appendix 6

### Sample Email and Follow-up Email

Sample Email& Facebook Post

Hello Playful Pooch Training Participants,

As part of my doctoral dissertation you are being invited to participate in a research study to assess counselor self-efficacy when conducting an animal assisted play therapy session. This study is being conducted by Karin Hansing, doctoral candidate, under the direction of Dr. Suhyun Suh in the Auburn University Department of Special Education, Rehabilitation and Counseling. You were selected as a possible participant because of your participation in Animal Assisted Play Therapy training offered through the Playful Pooch Program and because you are 19 years of age or older. Your participation in this study is completely anonymous.

This study will take between 15-20 minutes to complete. As an incentive to complete the survey, the -researcher will be donating \$1.00 for every complete response to the American Humane Association. The donation will aid in their efforts to “ensure the welfare, wellness and well-being of children and animals, and to unleash the full potential of the bond between humans and animals to the mutual benefit of both” (American Humane Association, 2013).

Please contact Karin K. Hansing at [kkh0006@auburn.edu](mailto:kkh0006@auburn.edu) or Suhyun Suh at [suhsuhy@auburn.edu](mailto:suhsuhy@auburn.edu) if you have any questions regarding this post.

The Auburn IRB has approved our study titled ” Self-Efficacy among Counselors Trained in Animal Assisted Play Therapy” for use from \_\_\_\_\_ to \_\_\_\_\_. Protocol # \_\_\_\_\_

To complete the survey please cut and paste the following link into your browser.

(Qualtrics link entered here )

Thank you in advance for your consideration and participation in our research study.



### Sample Follow-Up Email & Facebook Post

Hello Playful Pooch Training Participants,

As part of my doctoral dissertation you are being invited to participate in a research study to assess counselor self-efficacy when conducting an animal assisted play therapy session. If you have already participated in the study, thank you for taking the time to do so. Please disregard the remainder of this post. This study is being conducted by Karin Hansing, doctoral candidate, under the direction of Dr. Suhyun Suh in the Auburn University Department of Special Education, Rehabilitation and Counseling. You were selected as a possible participant because of your participation in Animal Assisted Play Therapy training offered through the Playful Pooch Program and because you are 19 years of age or older. Your participation in this study is completely anonymous.

This study will take between 15-20 minutes to complete. As an incentive to complete the survey, the -researcher will be donating \$1.00 for every complete response to the American Humane Association. The donation will aid in their efforts to “ensure the welfare, wellness and well-being of children and animals, and to unleash the full potential of the bond between humans and animals to the mutual benefit of both” (American Humane Association, 2013).

Please contact Karin K. Hansing at [kkh0006@auburn.edu](mailto:kkh0006@auburn.edu) or Suhyun Suh at [suhsuhy@auburn.edu](mailto:suhsuhy@auburn.edu) if you have any questions regarding this post.

The Auburn IRB has approved our study titled ” Self-Efficacy among Counselors Trained in Animal Assisted Play Therapy” for use from \_\_\_\_\_ to \_\_\_\_\_. Protocol # \_\_\_\_\_

To complete the survey please cut and paste the following link into your browser.

(Qualtrics link entered here )

Thank you in advance for your consideration and participation in our research study.