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## The Use of Animal-Assisted Interventions to Treat Child Victims of Sexual Abuse

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This thesis, written under the direction of the candidate's thesis advisor and approved by the program chair, has been presented to and accepted by the Department of Counseling Psychology in partial fulfillment of the requirements for the degree of Master of Science in Counseling Psychology.

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**The Use of Animal-Assisted Interventions to Treat Child Victims of Sexual Abuse**

By

Stephanie Johnston

A culminating thesis submitted to the faculty of Dominican University of California in partial fulfillment of the requirements for the degree of Master of Science in Counseling Psychology

Dominican University of California

San Rafael, CA

May 2021

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## **Abstract**

This study examines the therapeutic benefits of incorporating dogs into the mental health treatment of child victims of sexual abuse in both formal and informal settings. In 1962, Dr. Boris Levinson began incorporating his dog into therapy sessions with his child clients. He noticed that incorporation of dogs into psychotherapeutic treatment encouraged communication in withdrawn children and published his results in 1969, initiating a widespread interest in animal-assisted therapy (AAT). Other variations of AAT soon followed in the form of animal-assisted activities (AAA). The human-animal bond can be a powerful tool that effectively improves mental health and can play a significant role in supporting healthy child development. For children that have been sexually abused who are especially prone to being distrustful of other people, the opportunity to therapeutically work with a dog can feel much safer. The present study provides psychoeducation on the mental health effects commonly seen in child survivors of sexual abuse and a variety of evidence-based animal-assisted treatment options.

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## Terms and Definitions

**Sexual abuse:** Generally, refers to the sexual mistreatment of children by adults in a position of power. Mistreatment can include forcing the victim to touch or be touched by the perpetrator, watch sexual acts, look at naked pictures, watch sexual movies, and more. It can occur once or multiple times.

**Sexual assault:** The unwanted or forced engagement in a sexual act. This can be forced intercourse, forced oral sex, and/ or sexual abuse.

**Victim:** Someone who has been directly affected by sexual assault recently or long ago.

**Survivor:** Someone who has been directly affect by sexual assault that may or may not have completed the recovery process.

When deciding whether to use the term victim or survivor, it is best practice to let individuals tell you their preference. This manual will use the terms interchangeably.

**Perpetrator:** Someone who committed sexual abuse or assault.

**CSA:** Childhood Sexual Assault

**Animal-Assisted Activity (AAA):** “Is delivered spontaneously, may be carried out by professionals or volunteers and lacks a previously defined goal, documentation and evaluation.” (Glenk, 2017, p. 2).

**Animal-Assisted Therapy (AAT):** Is “carried out by professionals involved in preventive, curative, promotional or rehabilitative health care services, offering goal-directed procedures with animals as an integral part that require documentation and evaluation of intervention progress and outcomes” (Glenk, 2017, p. 2).

**Animal-Assisted Intervention (AAI):** Broad use of animals for therapeutic benefit such as in AAA and AAT.

**Human-Animal Bond:** The relationship between a human and animal that benefits both parties emotionally and psychologically.

## Preface

As a crisis hotline counselor for victims of sexual assault, I have learned how important it is for this population to have freedom of choice after their agency was so unfairly taken from them by their perpetrators. Unfortunately, due to the nature of legal matters, they must wait for their requests for restraining orders to be approved with the possibility of denial. They must face the possibility that their perpetrators may get released from prison or may never go to prison. They often experience a complete shift in their worldview where they typically trust people less and live more fearfully. The freedom to have a carefree life is completely taken from them as they learn to cope with the psychological damage they have incurred. Given these challenges, getting a call from a family seeking support options for a child victim of sexual assault is twice as heartbreaking. At the very least, these children should have the opportunity to choose a treatment option that they not only are comfortable with but can enjoy and receive fulfillment from too.

Animals have a beautiful way of connecting with humans in that they provide unconditional love and company. Dogs in particular have come to be known as “Man’s Best Friend” for the mutually beneficial relationship that can exist between a dog and a person. In providing dogs their basic care needs, humans receive affection and emotional support in return. For child victims of sexual assault who have an affinity towards dogs, there are numerous ways to incorporate dogs into their treatment. These survivors deserve the option to utilize these interventions.

## Introduction

This manual is intended to bring awareness to the various treatment options and therapeutic benefits that dogs can provide children who have been sexually abused. It presents the typical symptoms and negative effects that CSA (childhood sexual assault) victims experience and provides insight into why animal-assisted treatment methods are successful with this population. Survivors, family members and friends of survivors, mental health professionals, and CSA advocates can all benefit from this material. Survivors can learn about less conventional yet more effective ways to serve themselves and others can learn how to service survivors using interventions that are not widely known.

The animal-assisted treatment options that exist can be utilized at many different stages in the healing process of CSA survivors. Dogs can be used for short-term solutions such as providing comfort to survivors while testifying in court, participating in a forensic interview, and during trauma-related flashbacks. Additionally, dogs can offer long-term symptom relief through their incorporation in social, emotional, and psychological education. Cultural considerations should be considered before determining if animal-assisted interventions are appropriate for individual survivors.

While this manual focuses on the use of animal-assisted interventions to treat CSA victims, the literature review concentrates on anxiety specifically, a common symptom of CSA survivors. The 20/20/2 issue suggests that about 20% of children in the U.S. will need mental health treatment during their childhood. Only 20% of those children will actually receive treatment and only 2% of the treatment provided will be evidence-based care (U.S. Department of Health and Human Services, 1999, as cited by Hoagwood, Acri, Morrissey, & Peth-Pierce, 2016). While there is a clear need for more accessible and affordable treatment options for

children and youth, new treatment options must be offered only after they have been deemed as verifiably effective. In a 2009 literature review conducted by Frisen, various data suggests that participation of children in animal assisted interventions results in reduced heart rate and blood pressure, and increased confidence, focus, and cooperation in the therapeutic process. Other bodies of research support that the human-animal bond can play a crucial role in child development by aiding in the reduction of situational and generalized anxiety. As research continues to grow, the current data suggests that the use of therapy dogs via animal-assisted activities and animal-assisted therapies is a feasible, low-cost, and productive healing tool for children and youth experiencing anxiety.

## Literature Review

### Human-Animal Bond

The American Veterinary Medical Association describes the human-animal bond as “a mutually beneficial and dynamic relationship between people and animals that is influenced by behaviors considered essential to the health and well-being of both.” Although attachment theory refers to a bond between a mother and infant, it is theorized to be applicable to humans and their pets as well. This idea is supported by a study done in which participants “perceived their pets as distinctive sources of social support, at similar levels to their significant others, family, and friends” (Meehan et al., 2017, p. 273). Since social support is a crucial component of mental health, the human-animal bond can provide therapeutic benefits to humans that effectively reduce anxiety and stress in a variety of situations.

While humans can create special bonds with many different species, the therapeutic benefits offered from dogs, cats, dolphins, and horses are the most researched. When humans interact with dogs and cats, “levels of oxytocin (linked to bonding) and dopamine (involved in the reward-motivation system) are increased, while cortisol levels (an immunosuppressant associated with stress) are diminished” (Raje et al., 2018, p. 19). Dolphin interaction “is supposed to facilitate people with autism, down syndrome, and cerebral palsy with rehabilitation in motor function, voice communication and language as well as try and maintain and increase the client’s attention span” (Raje et al., 2018, p. 20). Horses offer a variety of therapeutic benefits through different methods. Hippotherapy is defined as “a physical, occupational, and speech-language therapy treatment strategy that utilizes equine movement as part of an integrated intervention program to achieve functional outcomes” (Raje et al., 2018, p. 20). This is different from equine-assisted therapy which is used for mental health treatment similar to dog

and cat therapy as it focuses on the human-animal bond rather than the physical benefits that come from horseback riding.

Because of the large space, amenities, and workload required to properly care for large animals such as dolphins and horses, facilitation of human interaction with these species for mental health benefits is not as convenient as with smaller pets. While many cats enjoy human interaction, it is not uncommon for cats to have a temperament that lacks the required patience for creating a human-animal bond. On the other hand, dogs are more likely to give affection and offer a friendly disposition. Thus, while cats and dogs require a lower effort of care than dolphins and horses, dogs are most likely to effectively promote the human-animal bond.

### **Dogs and Child Development**

Existing research suggests that child and adolescent populations can benefit from the dog-human bond in a variety of ways. Social relationships developed during childhood and adolescence significantly contribute to child development and these social relationships are not limited to human-human bonds. According to Purewal et al. (2017, p. 234), “There is growing evidence that children turn to their pets for comfort, reassurance and emotional support when feeling anger, sadness, or happiness” which indicates that dogs have the ability to provide mental health support to children. There are many factors to consider in determining why children and adolescents benefit from relationships with dogs. Physiological components such as the release of oxytocin contribute to feelings of pleasure from interacting with dogs. Attachment theory suggests that “when attachment behaviors are consistently met by the primary caregiver, children form secure internal working models (a cognitive framework consisting of mental representations for understanding the world, self and others) that are foundational for their ability to make affectionate bonds with others and to create and maintain close relationships” (Purewal

et. al, 2017, p. 234). While a dog is not a child's primary caretaker, dogs can still act as attachment figures in children's lives as their affection is reciprocal. Because of this, it can also be argued that through practice and implementation of social tools with a nonjudgmental figure, children feel supported and gain social confidence.

### **Animal-Assisted Activities v. Animal-Assisted Therapy**

Although animal-assisted activities (AAA) and animal-assisted therapy (AAT) are two different programs, both terms are often mistakenly used interchangeably. AAT is "carried out by professionals involved in preventive, curative, promotional or rehabilitative health care services, offering goal-directed procedures with animals as an integral part that require documentation and evaluation of intervention progress and outcomes" (Glenk, 2017, p. 2). In contrast, AAA "is delivered spontaneously, may be carried out by professionals or volunteers and lacks a previously defined goal, documentation and evaluation." (Glenk, 2017 p. 2). Current research suggests that both AAA and AAT have the potential to offer psychological benefits through use of the human-animal bond. For the purpose of this paper, animal-assisted interventions (AAI) will refer to the broad use of animals for therapeutic benefit such as in AAA and AAT.

### **Ethical Considerations**

When using dogs for AAI, it is important to maintain proper care and treatment of the animals while also ensuring that children participants are safe. Regular health checkups and vaccinations for the dog should be provided for the safety of the canines and the children and adolescents interacting with them. Depending on the nature of the intervention, dogs should also be given adequate breaks. The responsibility of the pet's care should fall on the professional dog handler that is present during AAI. Therapy dogs should undergo regular behavioral testing to

ensure they have a patient and friendly temperament, especially if they will work with young populations as children can be unpredictable. It is also best to have a dog with hypoallergenic fur to reduce the risk of an allergic reaction. Because many different types of AAI exist, “precise criteria necessary to ensure welfare in therapy animals are still missing” and “a universal standardization of guidelines remains challenging” (Glenk, 2017, p. 3).

The literature reviewed poses benefits of AAI for both situational and generalized anxiety. Situational anxiety occurs when one experiences anxiety over specific events such as an upcoming test or medical procedure. Generalized anxiety is classified as chronic anxiety that is not necessarily caused by specific factors. It can also exist because of trauma. Typically, AAA is used to treat situational anxiety as it can simply be applied prior to an anxiety-inducing event. AAT is usually used to treat generalized anxiety as it offers a structured long-term treatment plan. Because children often experience situational anxiety such as anxiety before an exam or doctor visit, AAA should be considered for its potential stress reducing benefits and ease of administration. At the same time, the Anxiety and Depression Association of America reports that approximately 25% of adolescents are affected by an anxiety disorder. For those suffering from a diagnosed disorder, AAT can be a nonthreatening intervention with a high attendance rate since treatment itself offers enjoyable aspects for those who enjoy spending time with animals.

### **AAA and Children in Medical Settings**

Experiencing anxiety is a common and normal response prior to a visit to the doctor or a medical procedure. This is true for children especially as they likely have not yet developed coping mechanisms and have learned to fear doctors due to their association with painful shots, intimidating tools, and delivering news of serious illness. Consider hospitalized children with serious illnesses who have had to adjust to daily living in a hospital, away from the familiarity of

their rooms, toys, and friends. AAA can be an effective, low risk, and low-cost treatment to reduce anxiety in children who experience significant stress related to medical procedures. Reductions in anxiety can contribute to the healing of children, better cooperation with medical staff, and increased success in completion of procedures.

In a study done by Chubak et al. (2017), child and young adult oncology patients visited with a therapy dog for approximately 20 minutes. During this time, patients were welcome to pet and watch the dog perform tricks without having to leave their hospital bed. Before leaving, the dog handler provided each patient with a keepsake that had the dog's photo on it. Patients completed a Distress Thermometer and Patient Reported Outcomes Measurement Information System (PROMIS) to indicate their levels of distress and mood type within the past seven days. Patients were also asked to complete a PedsQL Present Functioning Scale to report present feelings immediately following AAA. In addition to the self-report surveys, research assistants recorded behavioral observations such as whether the patient smiled and levels of interaction between patient and dog. Medical providers and staff were also asked to fill out surveys in which they shared their opinions about the general effectiveness of AAA as well as their perceptions of the effects of the dog-assisted interventions on their own patients. According to these measurement tools, medical providers and staff "believed that AAA had positive effects on patients" and reported that "distress in general and levels of worry and fatigue, in particular, appeared to decrease immediately following the therapy dog intervention" (Chubak et al., 2017, p. 337-338). These results were consistent with patient self-reports. Some parents and staff informally reported "that the dog visit was the first time the child had smiled or been happy in a long time" (Chubak et al., 2017, p. 338).

In a similar study, children hospitalized for various reasons spent time interacting with a therapy dog with a professional dog handler present. After the AAA, patients were given training on coping skills. Rather than interacting with a therapy dog, the control group was given a puzzle to complete and received the same coping education. Both groups filled out a State-Trait Anxiety Inventory for Children (STAI-CH) prior to and at the completion of their intervention. This measurement specifically assesses state anxiety which is anxiety about an event such as an upcoming medical procedure. Although both groups experienced a reduction in anxiety, results suggest “that a brief pet therapy visit more effectively reduces state anxiety than a comparative activity of completing a jigsaw puzzle” (Hinich, Kowalski, Holtzman, & Mobus, 2019, p. 59).

Perez et al. (2019) specifically focused on children between 4 and 6 years old who were scheduled to complete MRI exams. Not only was this motivated by a desire to ease the anxiety that children commonly experience before and during testing, but also to reduce anxious movement during the test which affects the accuracy of the results, requiring testing to be redone. With the help of their caregivers, each patient filled out an anxiety-measuring questionnaire developed by the researchers of this study before and after the animal-assisted intervention. During the intervention, children interacted with a dog and the dog was also used to help explain the MRI process. For example, the process of putting on headphones for the MRI was demonstrated on the dog. Of the 21 participants, 19 completed their MRI scans successfully and research concluded that the AAA “resulted in a beneficial effect on patients’ emotional status, easing anxiety in preparation for scheduled scans, without impacting MRI quality or duration” (Perez et al., 2019, p. 1000). These results suggest that AAA can effectively reduce

anxiety in children while also obtaining accurate test results without the use of sedation, which can be dangerous.

### **AAA and College Campuses**

For many college students, midterms and finals weeks are incredibly stressful times that can bring up symptoms of anxiety. During these weeks, campuses may see an increase in requests for counseling as students notice their increased stress levels and counseling centers may become impacted. Another consideration to make is the number of students who do not seek mental health services during this time despite increased stress due to stigma surrounding counseling. It is possible that they believe an attendance in therapy suggests they have serious clinical problems. They instead choose to rule out therapy in an effort to avoid being associated with mental health problems despite their anxieties being completely normal and expected. Perhaps some students themselves do not share this belief but are instead worried about a friend or peer seeing them walk in or out of the counseling center and believe this to be embarrassing. In consideration of these barriers to treatment for such a large population that is known to experience stress and anxiety at predictable times, research on bringing AAA programs to schools is beginning to rise.

Jarolmen and Patel (2018) tested the effectiveness of AAA in reducing test anxiety by measuring the blood pressures of students before and after their participation in the intervention. A control group simply had their blood pressure measured at their arrival and were then asked to wait behind a privacy divider for 15 minutes. They then had their blood pressure measured once more. The experimental group had their blood pressure measured prior to a 15-minute intervention with a therapy dog in which participants pet, spoke to, and played with the dog. Students' blood pressure was measured after the intervention as well. Both systolic and diastolic

blood pressures were measured from the control and experimental group as indicators of anxiety levels. The control group did not experience a significant change in systolic or diastolic blood pressure. However, “There was a statistically significant decrease in both systolic and diastolic blood pressure for the experimental group” (Jarolmen & Patel, 2018, p. 271). Not only do these findings suggest that AAA can sufficiently reduce test anxiety in college students within 15 minutes, but they also have further health implications. Systolic blood pressure is a “significant predictor of coronary heart disease and hypertension” (Cushman, 2000, as cited by Jarolmen & Patel, 2018, p. 268). Thus, through reduction of anxiety and systolic blood pressure, individuals may also reduce their risk of health complications.

### **AAA and Child Victims of Sexual Abuse**

Once allegations of child sexual abuse have been made, the victim must undergo a forensic interview. The interview process is defined as “a developmentally sensitive and legally sound method of gathering factual information regarding allegations of abuse or exposure to violence” (Newlin et al., 2015). The purpose of this interview is to collect information that can be used to further the investigation, obtain appropriate child protective services, and help mental health and medical professionals appropriately serve the child. For these reasons, it is crucial that child victims accurately report the abuse they experienced. To get accurate reports from children, it is important to understand the factors that may determine whether child victims choose to disclose their abuse or not. According to the Young Women’s Christian Association (YWCA), over 90% of victims know their perpetrator. Thus, disclosing who their perpetrator is, or even disclosing abuse occurred, can cause children to be fearful that their perpetrator will find out and punish them or repeat the abuse. The forensic interview can be intimidating as well as children are being asked to provide details of a traumatic event to a stranger. Additionally, due

to the trauma, some children may be in a state of shock making them incapable of disclosure. Given these factors and the importance of obtaining accurate disclosure, there is a clear need for methods that make children feel safe and comfortable during their forensic interview.

Previous research indicates that dogs act as a “form of social lubricant that can facilitate healthy and effective communication” and “increase feelings of security and warmth felt by the child” (Krause-Parello, Thames, Ray, & Kolassa, 2018). Understanding that a reduction in stress will increase the likelihood of accurate reporting, and that accurate reporting increases the likelihood that perpetrators will be prosecuted, and children will gain access to appropriate resources and protective services, incorporation of dogs into the forensic interview process is worth considering. Krause-Parello et al. (2018), conducted a study in which 51 children who were alleged to be victims of sexual abuse underwent forensic interviewing. Of the 51 participants, 29 were interviewed in the presence of a trained dog and 22 were interviewed without the presence of a trained dog. Various biomarkers were measured to indicate levels of stress of the children during their interviews. The results of the study showed a “significant decrease in heart rate [and] in systolic and diastolic blood pressure” (Krause-Parello et al., 2018) for those who had a dog present during their interview, indicating a reduction of stress due to presence of the dog. Of the 17 children who disclosed multiple instances of sexual abuse, 11 pet the dog during their interview, suggesting that physical interaction with the dog provided additional comfort. Given the vulnerability of the children being interviewed and the stress reducing implications of having a dog present during the interview, further research into this topic should be considered to obtain more knowledge on how to effectively serve child victims of sexual abuse.

## **AAT and PTSD in Children**

For children who suffer from generalized anxiety, beginning therapy with a stranger can be a nerve-wracking experience. Consider clients suffering from trauma that understandably are slow to open up, or clients with social anxiety disorder that naturally struggle to communicate. When clients are reserved (at no fault of their own), therapeutic progress becomes delayed as the alliance between therapist and client needs to be strengthened first. With some insurance companies limiting the number of sessions a client is allotted or for clients paying out of pocket, time and financial resources are limited. Thus, there is financial value in speeding up client comfort. In the 1960's, Dr. Boris Levinson found that some of his reticent clients became less withdrawn and experienced increased comfort when his dog was present in session (Bhattacharyya & Mukhopadhyay, 2014), thus talking more than they would have without the presence of the dog. Aside from the potential to make counseling services more affordable by decreasing the number of sessions required, speeding up client comfort increases the chances that client suffering can be reduced or alleviated sooner.

Signal et al. (2016) administered AAT to CSA victims, a population at high risk of developing PTSD and internalizing behaviors. The researchers of this study argue that CSA victims often have a complex presentation in treatment, sometimes making it difficult for engagement to occur in typical trauma treatment methods such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). To test the effectiveness of AAT on CSA victims, researchers scheduled child participants to meet and interact with a therapy dog once per week for approximately 25 minutes during the first three weeks of treatment. For the following seven weeks, participants worked with their social workers on the transference of interaction skills that were learned with the therapy dog to human interactions. At the completion of treatment,

caregivers of the children were asked to complete a Trauma Symptom Checklist for Young Children. Based on caretaker responses, participants experienced a significant reduction in trauma symptoms, including avoidance which is often a barrier to successful treatment (Signal et al., 2016).

In addition to these results, a literature review of all AAT studies done between 2000-2015 on participants between ages 3 and 20 years old found further supporting evidence that AAT is successful in reducing PTSD symptoms (Hoagwood et al., 2016). Qualifying studies used an experimental study design including a control group and were conducted on participants who have experienced traumatic events. Based on these criteria, three studies existed that specifically tested the effectiveness of dog-assisted therapy in treating PTSD and related symptoms. Of these three studies, “two found significant improvements in attachment (Balluerka et al., 2014, as cited in Hoagwood et al., 2016, p. 10), anxiety, depression, anger, PTSD, and dissociation (Dietz et al., 2012, as cited in Hoagwood et al., 2016, p. 10); the third found significant reductions in PTSD in the intervention group” (Hamama et al., 2011, as cited in Hoagwood et al., 2016, p.10). In a similar and more recently conducted literature review that solely focused on canine-assisted therapy on children, including international studies, researchers discovered “a significant decline in PTSD symptoms and a significant reduction in the risk for a PTSD diagnosis” (Jones, Rice, & Cotton, 2019, p. 13).

Based on these results, AAT has considerable potential in the treatment of PTSD as well as associated internalizing symptoms, such as anxiety, in children and adolescents. Due to the comfort and enjoyment gained from the human-animal bond, engaging in AAT can be an easier way to increase attendance and participation in therapy, something that can be challenging for adolescents in traditional one-on-one therapy modalities. With increased disclosure, therapists

and clients can collaborate on treatment of mental health issues at a more effective rate in a timely manner.

### **AAT and Adolescent Psychiatric Populations**

Being admitted into a psychiatric hospital can be a frightening and dehumanizing experience, especially as an adolescent. Patients may be asked distressing questions and their personal belongings are searched through, further contributing to anxiety. They are stripped away of familiarities and abruptly placed into a brand-new environment with little time to adjust. While some may benefit from developing social relationships with other patients, this may be a challenging and nerve-wracking component for others. Bringing therapy dogs into psychiatric hospitals can provide patients with feelings of comfort and safety in an environment that induces high levels of stress and uncertainty.

In a study conducted by Stefanini et al. (2015), hospitalized adolescents with severe psychiatric disorders participated in AAT programs with specific goals that related to their unique needs over the course of three months. During the first phase of treatment, participants simply familiarized themselves with the therapy dog and handler. In the second phase, participants engaged in individualized interventions. The third phase required participation in a group activity and the fourth phase required participation in a discussion about the experience. Common activities during therapy included playing, grooming, walking, and obedience training. Levels of functioning were measured using the Children Global Assessment Scale. For comparison, a control group was also included in the study. Participants of the experimental group experienced “an increase in their global functioning, a significant reduction of time spent in hospital, and a significant increase of ordinary school attendance compared with the control group patients” (Stefanini et al., 2015 p. 44-45). Three months after the conclusion of treatment,

participants “showed significant changes in social participation and social interaction skills with adults and peers, more active and frequent interactions with their assigned animal and more affective behaviors towards them” (Stefanini et al., 2015, p. 45). These findings imply long-term incorporation of a dog into structured therapy can provide lasting benefits to children suffering from acute mental health problems.

### **AAT and Incarcerated Populations**

Incarcerated youth are usually convicted for antisocial behaviors which include a general lack of understanding or care for others’ feelings. While many facilities offer substance use treatment to incarcerated youth (Seivert et al., 2016), there is still a large need for psychological treatment options to address the lack of empathy in this population as it relates to their commitment of crimes. In an effort to improve empathic levels and thus decrease recidivism rates, AAT is being considered as a treatment method for incarcerated youth as interaction with a therapy dog can improve prosocial behaviors. This is supported by a study done in which the presence of a dog in working groups “evidenced more verbal cohesion and physical intimacy,” and “members spoke in a more positive and friendly manner to one another and group members were more likely to make eye contact, lean toward one another, and touch one another” (Collarelli et al., 2017, p. 84-85).

Seivert et al. (2016) conducted a study in which incarcerated youth participated in a ten-week AAT program by attending two-hour sessions twice per week. The first hour of attendance required engagement in a didactic animal education course. Materials taught included emotion identification in animals and people, pet care, and the importance of shelter adoption. The second hour of treatment involved training and readying a dog for adoption from a shelter. The researchers theorized that this would generate a greater understanding of the dog’s needs and

therefore create a strong bond between each participant and his or her corresponding dog. For comparison, members of the control group attended the same courses, however they did not receive training in the procedures required for readying dogs for adoption. Instead, they walked a different dog each time, decreasing the chances that a strong relationship could be formed. Internalizing and externalizing behaviors were measured through a Youth Self Report. Prison staff were also asked to complete the Teacher Report Form.

Based on the data collected from the Youth Self Reports and Teacher Report Forms, a significant increase in empathic concern was observed in both groups (Seivert et al., 2016). While researchers hypothesized that the control group would experience a smaller increase in empathy when compared to the intervention group, the research found that the incarcerated youth simply benefitted from interaction with dogs, regardless of whether they built a relationship with one dog overtime or spent time with a different dog each week. This also implies the potential effectiveness of the didactic training alone, as both groups received identical courses. Another unexpected result of this study was the increase in reported internalizing behaviors. The researchers believe that through interaction with animals and participation in the didactic course, the participants may have gained awareness of their own emotions, thus increasing feelings of sadness, fear, or anxiety. It should also be considered that as the study continued, time spent in incarceration increased which could lead to a natural rise in internalizing issues. Although an increase in internalizing issues presents initial challenges for individuals that have yet to learn how to cope with new negative feelings, this may initiate the long-term benefit of gained empathy, and a potential reduction in recidivism. For a population that is not emotionally attuned, seeing a rise in internalizing behaviors after AAT should be considered a benefit as it suggests a newly learned skill in emotion identification.

## **Limitations**

Although the research cited in this paper is of peer-reviewed, published journal articles, there are limitations to consider. For the control groups used, it is difficult to know whether comparable interventions were given. For example, participants of the control group in the study done by Hinic et al. (2019) were asked to complete a puzzle instead of interacting with a dog. It is possible that some children find doing a puzzle a stressful, unenjoyable activity that increases stress levels. Members of the control group were also given coping skills education during the time they were given to solve a puzzle, while the experimental group received the training separate from their intervention with the dog. For those engaging in the puzzle activity, a didactic lesson may have been distracting, further contributing to heightened stress or lack of enjoyment during the puzzle intervention. Similarly, in the Jarolmen and Patel (2018) study, members of the control group simply sat behind a divider for 15 minutes. Sitting in a closed off area with little to no stimulation in an unfamiliar setting has the potential to induce anxiety. Thus, it is not known for certain whether the control groups were given neutral or equal interventions.

It should also be recognized that in some cases, data was measured through self-report only while other studies collected reports from caretakers only. To obtain a more comprehensive set of results, both types of reports should be collected. Self-report is important as researchers should receive information from participants themselves about their own experiences and feelings. However, to mitigate the risk of inaccuracies that can occur from children misunderstanding survey questions, caretaker reports should also be obtained for the reporting of observable information

## **Conclusion**

Animal-assisted interventions offer therapeutic benefits to children of diverse populations suffering from minor to acute anxiety. For a population that is incredibly underserved, considerations for AAI should be taken for its low-cost, convenience, and kid-friendly approach. Dogs in particular can provide children an escape from the challenges that are complicating their lives by offering an automatic warmth and friendliness that truly radiates acceptance while improving mental and physical health. As a relatively new concept, further studies should be done on AAI so that official standards and expectations can guide the creation of future treatment options under ethical and effective terms, while also being empirically supported.

## **Section 1: Statistics**

While no measure of national sexual abuse in children and youth is fully accurate, statistics from Child Protective Services (CPS), the Justice Department, and the Department of Health and Human Services provide the most comprehensive evidenced-based data. The Justice Department conducts annual studies using the National Crime Victimization Survey (NCVS) in which Americans are interviewed about the crimes they survived. Although the NCVS provides the most reliable view of crime statistics in the United States year-round, it still has some significant limitations. Children under the age of 12 are not interviewed for the NCVS to decrease their risk of being further traumatized. Additionally, based on the survey results, estimates must be made to include crimes that were not reported. It is often the case that many sexual assaults go unreported due to embarrassment and fear held by the victims.

### **Victims**

As reported on the Rape, Abuse, & Incest National Network (RAINN) website (<https://www.rainn.org/statistics/children-and-teens>), using data from 2016, CPS found strong supporting evidence to indicate that approximately 57,000 children per year are victims of sexual abuse (2018). RAINN's website, whose primary source of data is informed by the NCVS, also reports that 66% of sexual assault victims under the age of 18 are ages 12-17, 82% of victims under age 18 are female, and females age 16-19 are four times more likely to be victims of sexual violence when compared to the general public (2020). Approximately 11% of girls and 1.8% of boys will experience some form of sexual abuse (Finkelhor et al., 2014). Evidence is found by CPS to support that claims of sexual abuse of a minor are made every nine minutes, as reported by RAINN's website (2020).

## **Perpetrators**

“Stranger Danger” is a widely known concept that was created to educate children to avoid speaking to and going places with someone they do not know. Although well-intentioned, this idea has instilled the common misconception that children are often abducted or sexually abused by strangers. The truth is that 93% of children are sexually assaulted by people that they know with 59% of the perpetrators being acquaintances, 34% being family members, leaving the remaining 7% as strangers (RAINN, 2020). Of all sexual abuse cases reported to CPS in 2013, approximately 47,000 of the alleged perpetrators were male and 5,000 of the alleged perpetrators were female, and of substantiated claims, 88% of the perpetrators are male and 9% are female (RAINN, 2020).

## **Mental Health Outcomes**

Minors who experience sexual abuse are at high risk of developing mental health disorders due to the tragedy and trauma they experience as victims of childhood sexual abuse. When compared to non-victims, children who were sexually abused are four times more likely to abuse substances, four times more likely to experience PTSD in their adulthood, and three times more likely to have at least one major depressive episode in adulthood (Zinzow et al., 2012). Sexually abused minors “have a 2- to 3-fold higher risk of suicidal ideation and 3- to 4-fold higher risk of attempted suicide than nonvictims” (Perez-Gonzalez & Pereda, 2015, p. 149). Dissociative symptoms at the clinical level can be eight times as likely to occur in CSA victims and behavioral problems are at increased risk of developing (Collin-Vezina, Daigneault, & Hebert, 2013). Each of these mental health challenges can follow survivors into their adulthood, having long-term negative effects on their relationships with friends, family, and significant others.

## Section 2: Mental Health Effects

The below listed disorders represent some of the more common diagnoses that can result from CSA. It should be highlighted that each survivor's experience is completely unique when considering multiple relevant factors such as family history, social history, and the type, severity, and frequency of the abuse experienced, thus the disorders that develop are not limited to what is subsequently listed. While development of a mental health disorder is a common consequence of CSA, it is not a guaranteed outcome, and it is difficult to predict who is more likely to meet the standards for diagnosis as some individuals have more resilience than others. Additionally, a survivor may have some symptoms of a disorder while not meeting all criteria for that disorder in the *Diagnostic and Statistical Manual of Mental Disorders (DSM), Fifth Edition (DSM-5)*, the primary guidebook used by mental health professionals to determine a mental health diagnosis. This does not discount the severity of the symptoms felt by the survivor, nor does it disqualify their need for mental health treatment. Hence it is possible for one to suffer from moderate to extreme mental health conditions without a technical diagnosis.

### **Post-Traumatic Stress Disorder (PTSD)**

In order to obtain a PTSD diagnosis, there are eight main criteria that one must meet (criteria A-G) according to the DSM-5: exposure to death, serious injury, or sexual violence, intrusive symptoms such as nightmares or flashbacks, avoidance of stimuli that remind one of the trauma, negative thoughts and feelings that became worse after the traumatic event, arousal and reactivity that became worse after the traumatic event, symptoms last for at least one month, symptoms cause distress or functional impairment, and symptoms are not the result of medication or substance use (American Psychiatric Association, 2013). While the DSM-5 describes the symptoms of PTSD, it does not address the effects of these symptoms. PTSD

during childhood can have significant adverse ramifications on a child's development that can turn into long lasting issues if carried into adulthood. Some examples of these effects may include, but are not limited to, difficulty understanding boundaries, inability to trust others, difficulty developing and maintaining relationships, difficulty understanding emotions, inability to self-regulate, difficulty focusing in school, difficulty communicating with others, dissociative behaviors, behavioral issues such as poor impulse control or overcompliance, and low self-esteem. For instance, if a child has repeated intrusive and uncontrollable flashbacks of the sexual abuse, it is possible that these flashbacks would occur during class or as the student attempts to do homework. These flashbacks would then negatively impact that student's ability to focus on schoolwork, thus making it difficult to succeed academically. If one has difficulty achieving academic success, this could have a negative impact on that individual's ability or desire to attend college. This then increases the chances that the individual will experience difficulty obtaining a financially secure career in adulthood. To take it a step further, feelings of inadequacy can develop when one experiences embarrassment from his or her academic and financial struggles, leading to low self-esteem, another effect of PTSD, thus illustrating the complexity of PTSD and its intertwining forces.

### ***The Traumagenic Dynamics Model***

Because CSA victims have a high likelihood of experiencing long-term trauma, and trauma has many intricacies that are generally not well understood by the public, it is important to address the vulnerabilities caused by CSA trauma, especially complex trauma which can transpire when the sexual abuse occurs repeatedly. The Traumagenic Dynamics Model developed by Finkelhor and Browne (1985) provides a framework that conceptualizes the four main consequences of childhood sexual abuse. The model is based on the idea that a child

victim of sexual abuse will experience a shift in his or her view of the self and the world due to four trauma-causing dynamics: traumatic sexualization, betrayal, stigmatization, and powerlessness (Finkelhor & Browne, 1985). As described by Collin-Vezina et al. (2013):

- Traumatic sexualization is representative of the victim's view of his or her sexuality that becomes shaped by the abuse, typically causing a distorted view of sexual norms.
- Betrayal is the victim's loss of trust in the perpetrator and possibly other individuals who are interpreted by the child as not having protected him or her.
- Powerlessness develops because of the child's loss of sense of control over one's own fate due to the powerlessness experienced during the sexual abuse.
- Stigmatization is the child's belief that he or she is guilty or bad which can be caused by comments made by the perpetrator, the media, friends, and family members such as "her skirt was short, so she must have wanted it."

### **Depressive and Anxiety Disorders**

In a study conducted on victims of CSA, it was found that they are twice as likely to experience depression and anxiety than non-CSA victims (Li et al., 2012). Considering this statistic, it is also important to address that the duo of depression and anxiety in youth is one of the most common occurring comorbidities in mental health with rates ranging from 15-75% comorbidity (Cummings et al., 2014). Depressive episodes can appear in various DSM-5 disorders such as Major Depressive Disorder, Dysthymia, Bipolar Disorder, and more. Similarly, anxiety can appear in Panic Disorder, Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, and others. Typical depressive symptoms include, but are not limited to insomnia, fatigue, depressed mood, loss of interest in activities, suicidal ideation, and poor appetite

(American Psychiatric Association, 2013) while anxious disorder symptoms can manifest as excessive worry, restlessness, sweating, heart palpitations, and more (American Psychiatric Association, 2013). Similar to the effects of PTSD, the comorbid effects of anxiety and depression can make it difficult for children to develop strong interpersonal relationships if they are plagued with a plethora of symptoms that negatively impact their ability to relate to others. Academics can also become affected if these symptoms interfere with abilities to concentrate or develop interest in curriculum. Again, as with PTSD, these effects can be long-term, continuing to present themselves in adulthood.

### **Substance Use Disorders**

Because of the temporary relief from stressors that substances can provide, it is common for CSA victims who develop trauma, depressive, anxious, or any combination of these disorders to use substances to informally treat their symptoms. A DSM-5 substance use disorder can be mild, moderate, or severe, dependent upon how many of the following symptoms present in the individual (American Psychiatric Association, 2013):

- Use of the substance in large amounts, or for longer than intended
- A desire to reduce use, but inability to do so
- A large amount of time is spent using, obtaining, or recovering from the substance
- Craving of and urges to use the substance
- Work, home, and/ or school life is negatively impacted by use of the substance
- Continued use of substance despite knowing it negatively impacts interpersonal relationships
- Reduced or stopped participation in recreational activities due to substance use
- Continued use of substance despite it causing dangerous situations

- Continued use of substance despite it causing or worsening physical or psychological conditions
- Increased tolerance of the substance
- Development of withdrawal symptoms that are subsided by reusing the substance

Since the adolescent brain is still developing, regular use of substances during this stage of life can result in long-term cognitive problems such as predisposition toward risky behavior, poor memory, and increased likelihood of making choices that provide immediate gratification without considering the long-term consequences (Gray & Squeglia, 2018). Risky behavior examples include committing crimes, (which can lead to jail or prison time), unprotected sexual activity (which can lead to health issues), and dangerous driving (which can result in injury or death), to name a few of many. Poor memory can make it difficult to achieve satisfactory grades in school and discourage motivation to try as it increases the effort needed to learn new material. Prioritizing immediate reward over long-term rewards can negatively affect how one manages finances (shopping for an excess of clothes instead of saving for rent) or diet (eating for enjoyment in excess instead of implementing healthy food choices). Ultimately, the chain reaction that can occur when a child experiences trauma, depression, anxiety, or substance abuse not only leads to mental health challenges, but also long-term difficulties in typical markers of life success.

### **Section 3: Animal-Assisted Interventions as Treatment Options**

Child victims of sexual assault have experienced an extreme violation of trust by the perpetrator, understandably making victims weary of people, and affecting their ability to trust new adults. As highlighted in the Traumagenic Dynamics Model, victims may even lose trust in familiar adults such as their own parents as they may hold the adults in their lives who were

supposed to keep them safe accountable for failing to do so regardless of how preventable the assault was. For children who are not ready to accept new adults into their lives, the concept of doing therapy with an adult stranger can be frightening and anxiety-inducing, further enhancing symptoms that may already exist because of the assault. Given this possibility, animal-focused therapies and interventions for the treatment of CSA victims specifically is a compelling option as it reduces the tension of meeting a new adult. This reduction in stress can be attributed to the human-animal bond and its ability to foster social support, a critical component of mental health, during the initial stages of treatment when meeting newcomers can feel overwhelming for CSA victims. Additionally, long-term use of animal-assisted interventions in treatment can continue to be of benefit to the victims in a variety of ways.

For the purpose of this manual, AAI (animal-assisted interventions) will be used as an all-encompassing term that accounts for both short-term and long-term treatment options in which an animal is incorporated for the benefit of one's mental health. To reiterate terms defined in the literature review, an AAA (animal-assisted activity) is "delivered spontaneously, may be carried out by professionals or volunteers and lacks a previously defined goal, documentation and evaluation." (Glenk, 2017 p. 2). In contrast, AAT (animal-assisted therapy) is "carried out by professionals involved in preventive, curative, promotional or rehabilitative health care services, offering goal-directed procedures with animals as an integral part that require documentation and evaluation of intervention progress and outcomes" (Glenk, 2017, p. 2). While humans can benefit from the use of AAI involving many different species, dogs are most likely to have a predictable and affectionate temperament while also requiring a relatively low maintenance effort.

While there is no standardized list of dog breeds that is used to determine the most eligible candidates for AAI, any dog used should be “friendly and non-aggressive, confident, patient, calm, gentle and receptive to training” (Bono et al., 2015, p. 2). Problem behaviors that should be avoided are “jumping up, biting, inappropriate urinating, excessive sniffing, excessive vocalization, and inappropriate eating” (Urichuk & Anderson, 2003, p. 132-133). Some examples of breeds that generally meet these requirements are Border Collies, Golden Retrievers, Labrador Retrievers, and Shetland Sheepdogs. However, dogs of any breed or mixed breeds can be just as qualified for AAI provided that they have undergone proper evaluation.

For formal evaluation of a dog as well as the relationship between dog and owner, U.S. residents can obtain online training with Pet Partners at [www.petpartners.org](http://www.petpartners.org). Before receiving official certification, each dog and owner must pass an in-person exam in which dogs are individually tested on their temperament and both the dogs and their owners (or handlers) are tested on their compatibility as a team. This type of certification is typically required for conducting formal animal-assisted interventions such as AAT. Although training may not be required for a dog to participate in AAA, it is safer for both clients and pets if the dog becomes certified before conducting any work with clients. It is strongly recommended that an assessment is done of any dog that is going to work with CSA survivors as this population is especially vulnerable.

### **Animal-Assisted Activities**

During a forensic interview, children are asked questions that help law enforcement officers further their investigations and determine what kind of action should be pursued to protect the children involved moving forward. Thus, children are being tasked with reliving and sharing their traumatic experiences with a stranger. If children feel safe during this process, they

are more likely to disclose information that they may otherwise feel too scared to share. It is also important for children to feel safe simply for the sake of their comfort after experiencing sexual abuse. Having a dog present during the forensic interview gives children the opportunity to use the dog as a safe barrier between themselves and the interviewer and helps “increase feelings of security and warmth felt by the child” (Krause-Parello et al., 2018, p. 4). The dog’s presence alone can be a source of comfort for a child just by being present in the room, not leaving the child alone with the interviewer. Petting the dog during an especially challenging interview question provides comfort. The dog may even be a focal point for the child to look at while sharing what s/he considers to be shameful or embarrassing information. It is also possible that knowing the dog cannot understand what is being said, nor can the dog share this information with others, provides a sense of security to the child. As described in the literature review, Krause-Parello et al. (2018) found that when compared to children who were forensically interviewed without a dog present, those who did have a dog in the interview room saw a “significant decrease in heart rate [and] in systolic and diastolic blood pressure” (p.2). Additionally, 11 out of 17 children that disclosed they were victims of repeated sexual abuse pet the dog while disclosing (Krause-Parello et al., 2018). Not only do disclosures from children provide critical data points to investigations, but they also increase the likelihood that appropriate action will be taken to protect the child. For example, it would be more challenging for police to obtain a restraining order against an alleged perpetrator without the child having disclosed his/her abuse during the forensic interview. Thus, using AAI in forensic interviewing can immensely assist professionals in effectively serving child victims of sexual abuse.

Another anxiety-inducing aspect of reporting one’s sexual abuse is testifying in court. Not only does this have to be done in the presence of a judge and attorneys, but the child

must also come face-to-face with his/her perpetrator. Being called as a witness and asked to share one's abuse in the presence of one's perpetrator can be traumatizing and terrifying while also potentially leading to a weakened testimonial. For these reasons, having a service dog present should be considered to both soothe the child as well as elicit a more accurate narrative. In a law review on the use of therapy dogs in courtrooms, Bowers (2013) shares multiple stories in which this intervention is effective. In one instance, a boy who was sexually abused by his mother "had been reluctant to testify; however, once introduced to Jeeter [a Lab/golden retriever], the boy told his entire story to attorneys and police" (p. 1299). In another instance, two seven-year-old-girls who were experiencing distress while testifying were accompanied by the same dog. Upon noticing their distress, Jeeter placed his head on their laps to comfort them and one girl pet him throughout her testimony (Bowers, 2013). Another child, age four, had a therapy dog at his feet during his testimony, allowing him the opportunity to pet the dog as he became stressed (Bowers, 2013). In her 16 years of prosecution experience, Judi Johnson shared that the presence of service or therapy dogs was the only intervention that effectively reduced the stress of child victims of sexual abuse during trial (Bowers, 2013). For a population that has been terribly wronged, the option for interventions that can assist them through their trauma should exist in every situation where possible.

The therapeutic benefits of having a dog present are not limited to short-term interventions. Having a secure attachment figure is critical during a child's development for overall well-being and ability to connect with others socially in a healthy way. In one study done on child abuse victims, "reports of a secure attachment to a pet were four times more likely than a secure attachment to their human caregiver" (Wanser et al., 2019, p. 473). Having a pet as a companion animal can offer children a secure attachment figure, which can be especially

beneficial for children who experienced sexual abuse by a parent, or have difficulty trusting adults in general because of their abuse. Various studies have supported that physical touch from caregivers is essential to developing a secure attachment. However, given the nature of the abuse endured by CSA victims, it is very possible that they would not be comfortable with physical touch for an extended period of time, during which developmental outcomes are being shaped. Dogs can provide children a more comfortable option for physical touch as a way of comforting children while also continuing their social development. Having a dog as a pet allows for the dog to be a consistent and stable source of security for children in which the dog is seen as “accepting, non-judgmental, [and] more forgiving than people” (Wanser et al., 2019, p. 474). Additionally, the belief that dogs “do not care about a person’s history can be grounding and calming” (Wanser et al., 2019, p. 474). Having the dog be a part of the family gives the child an opportunity to develop a strong bond with the pet, increasing the therapeutic value in the human-animal bond that exists, while also giving immediate and frequent access to the therapeutic benefits provided by the pet.

### **Animal-Assisted Therapy**

Dietz et al. (2012) conducted a study in which 153 CSA victims participated in group therapy for the treatment of trauma symptoms, including anxiety and depression. The participants were divided into three groups: Group 1 in which there was no utilization of dogs nor storytelling during therapy, Group 2 in which dogs were incorporated into therapy, but without a storytelling component, and Group 3 in which dogs and storytelling were both utilized during therapy. Group therapy was chosen so that children could have the opportunity to develop a system of support with others who had undergone similar abuse. In developing these relationships with other children, participants simultaneously learn to trust others again, a skill

that typically must be relearned after being abused by a trusted individual. Storytelling was used to facilitate self-expression using a method familiar to children. In doing so, “they are likely to relate to [the stories] and connect to the characters and situations in the stories, which can enhance the therapy (Dietz et al., 2012, p. 668). The goal of incorporating a dog into the therapy room was to soothe children during disclosures of their abuse.

Each therapy group was designed to discuss common challenges that CSA victims are faced with such as boundaries, trust, and self-esteem. Group 2 incorporated dogs into therapy by including them and their trained handlers in the introductory activity for approximately 15 minutes. In Group 3, educational stories were told from the dog’s perspective to teach the children how to overcome the challenges they were facing. Once the storytelling was done, the dog left the room, and the therapist and children engaged in a discussion in which children related the stories to their abuse and asked questions. The therapist answered questions and kept the conversation therapeutic.

To measure success of each therapy group, participants were asked to complete a Trauma Symptom Checklist for Children (TSCC; Briere, 1996) before attending their first therapy group and after completing their twelfth session. The TSCC is a self-report tool that consists of 54 questions that assess “children’s reaction to trauma on 10 clinical scales: anxiety, depression, anger, PTSD, dissociation, overt dissociation, fantasy dissociation, sexual concerns, sexual preoccupation, and sexual distress” (Dietz et al., 2012, p. 672). While all groups showed a decrease in symptoms, the two groups that incorporated dogs into the therapy group showed a larger improvement in their symptoms, with Group 3 showing the most improvement. Thus, even if symptoms reduced as a result of time passing, the groups with dogs in their treatment still saw greater improvement, implying that AAT was especially effective. By including the dog in

the introductory activity of Group 2's sessions, participants were put at ease, more comfortable engaging in discussion, and therefore more receptive to therapeutic treatment. Using the dog as a character in the stories being told, made it easier for children to talk about the challenges they face being survivors of sexual assault as they were able to use the dog as a reference point instead of themselves. They could initially participate in group discussion by making assumptions about the dog's feelings rather than their own. Once ready, they then could transition into talking directly about themselves by connecting similarities between themselves and the dog. For example, a child might first feel more comfortable discussing how fearful the dog character must be after having been touched unwantedly before outwardly talking about how fearful they themselves are after having experienced the same abuse.

In summary, animal-assisted therapy for abused children can strengthen the therapeutic process by producing more effective results in less time, alleviating suffering sooner in a preferable fashion. Should mental health professionals wish to incorporate animal-assisted therapy in their practice, it is important that certain goals are monitored for effectiveness throughout treatment so that if necessary, adjustments can be made to ensure a reduction of symptoms and an improvement in well-being. As summarized by Parish-Plass (2008), AAT should work to provide the following benefits:

- **Facilitating connection:** Many times, children who have experienced abuse develop a general mistrust of the world. Attending therapy in which they are asked to share their most vulnerable moments with a therapist they have no previous relationship with can be an extremely difficult challenge to overcome. Yet, this is completely necessary for therapy to be effective. In simply observing how a therapist positively interacts with the dog, "the child often perceives the therapist in a more positive light and feels less

threatened” (Parish-Plass, 2008, p. 13). As a result of this, the child becomes more comfortable engaging with the therapist.

- **Safety of the therapy environment:** In observing that the dog is safe while in the room with the therapist, children make the connection that they too will be safe in that room. This is especially important for sexual abuse victims. Having a dog present also sparks natural conversation topics, helping them to gain a sense of normalcy in an unfamiliar setting.
- **Acceptance:** Dogs are nonjudgmental which allows children to feel comfortable sharing their emotions sooner than they would have without a dog’s presence. When the therapist models patience for and acceptance of the dog when the dog “misbehaves” (i.e., if the dog does not follow a command initially), the children may relate to the dog and expect to receive the same acceptance from the therapist too.
- **Reality at a safe psychological distance:** As living beings, dogs will create unpredictable scenarios in the therapy room that allow children the opportunity to react in the present moment while still feeling safer than the unpredictability of human interactions. These interactions “provide an opportunity for role playing, projection, transference, and reenactment of experiences from the past, thus enabling emotional content, such as aggression, sexual issues, sickness, anger, fear, anxiety, sadness, and rejection, to come to the surface and be worked through” (Parish-Plass, 2008, p. 13).
- **Self-esteem:** In developing a relationship with a dog, children gain confidence in their social skills while also learning appropriate behaviors. For example, if a child is aggressive with the dog, this can be used as a learning experience in that the therapist

highlights how the dog does not like aggression. Thus, the child learns to be gentle and is rewarded with the dog's affection.

- **Empathy:** In teaching children that dogs have physical and emotional needs, they learn how to have empathy for the dog which acts a catalyst to learning to have empathy for other humans. For example, in AAT, children learn that dogs have basic needs such as the need for food, water, and physical activity, and that they also have emotional needs for affection and physical touch.
- **Need for control:** For sexual abuse survivors, gaining a sense of control back is incredibly important. Working with a dog in therapy allows for survivors to explore social interaction in a controlled environment as they begin to acclimate to the real world.
- **Touch:** Dogs present children the opportunity for comfort through physical touch which can be an extremely sensitive topic for survivors of sexual assault. AAT can also be used to educate survivors about appropriate and inappropriate touch by teaching them where the dog likes to be touched and where the dog does not like to be touched. This teaches children boundaries about touch since those boundaries have been blurred by their abuse.

These guidelines give administrators of AAT a reference point to ensure that their therapy is goal oriented. Having goals is a requirement of ethical therapy as they set in place measurable items that should be monitored regularly so that if goals are not being met, changes in therapy can be made.

### **Human Diversity Considerations**

Before considering an animal-assisted intervention as a treatment option, it is important to understand the individual identity of the survivor seeking help. For example, Muslims follow the teachings of the Quran which describes dogs as impure and unclean. Therefore, it is common

for some Muslims to view dogs negatively, likely meaning they would not have interest in using dogs for therapeutic benefit. In Kenya, there is a prominent wild dog population in which Kenyans may allow the dogs to sleep in their yards and act as guard dogs, but no further relationship exists between individuals and dogs such as what commonly occurs in the United States. Thus, AAI may seem odd or even undesirable for some Kenyans. In these instances, it would be inappropriate and unethical to encourage CSA survivors to participate in AAI. It is important for clinicians to understand these beliefs and accept them without judgment, and to never persuade one who is not comfortable with dogs to participate in AAI.

For children with physical disabilities, it is important to make sure any dog they are encountering is well-trained to mitigate risk of physical harm. Although any dog used in AAI should be well-trained, this is especially true for children with physical disabilities as they may not be as agile and able to remove themselves from harm. To decrease risk of an allergic reaction to pet fur, hypoallergenic dogs should be considered for treatment. However, simply asking children and their parents about the child's history with dogs will provide insight as to whether an allergy exists.

While some programs offer dog-assisted interventions at no cost, such as dog accompaniments to court, long-term treatments that are typical in AAT typically have costs similar to traditional therapy. It is important for mental health professionals to be mindful of each family's socioeconomic status before considering giving referrals or recommendations for AAT. Referring a child to treatment in which his or her family cannot afford can be a demoralizing experience that may discourage the family from considering any treatment all together as they may develop a belief that affordable options do not exist.

## Conclusion

Based on the numerous studies presented in this manual, it is undeniable that incorporating dogs into the therapeutic treatment of CSA survivors can enhance the therapy by providing comfort, bridging the relationship between therapist and survivor, reducing trauma symptoms, and aiding in psychoeducation. Due to the high risk CSA survivors face of developing mental health challenges, it is necessary to consider evidence-based treatment options that are effective. Effective therapy treatment will help CSA survivors in the present moment and have positive implications for their adult lives too. Dogs can provide children with radiating warmth, compassion, and support through their natural ability to be nonjudgmental and innate desire and ability to bond with humans. By creating that connection, CSA survivors are given the opportunity to heal from the terrible injustice they have endured. Dog-assisted interventions allow for children to slowly integrate back into the real world by practicing real world interactions with a safe being before fully integrating to human-human interactions. Children soon learn that no matter what they look like, what religion they practice, what family history they have, what their socioeconomic status is, or what mental health disorder they have, a dog will love them unconditionally. This provides a level of safety that human-human interactions cannot and for CSA survivors, establishing safety is critical before effective treatment can begin.

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**Appendix A: Resources for CSA Survivors in Sonoma County**

Table 1 Resources for CSA Survivors in Sonoma County

<b>Name</b>	<b>Address</b>	<b>Phone Number</b>	<b>Services</b>
Chrysalis Community Counseling Services	1821 4 <sup>th</sup> Street Santa Rosa, CA 95404	(707) 545-1670	Sliding scale feminist counseling, victim assistance, CPS funding
Chanate Hall Youth and Family Outpatient Services	3333 Chanate Road Santa Rosa, CA 95404	(707) 565-4810	Mental health services for high-risk children (Medicare)
YWCA	811 3 <sup>rd</sup> Street Santa Rosa, CA 95404	(707) 546-9922 Hotline: (707) 546-9928	Domestic violence counseling, emergency shelter
Inter-tribal Council of California, Inc.	3425 Arden Way Sacramento, CA 95825	(707) 521-4555	Emergency shelter, transportation, food, clothing, legal advocacy for those of Native American ancestry
Jewish Family and Children Services	1360 N. Dutton Ave Suite C Santa Rosa, CA 95401	(707) 303-1500	Counseling, food, case management, post-adoption help
Family Justice Center of Sonoma County	2755 Mendocino Ave Santa Rosa, CA 95403	(707) 565-8255	Advocacy, victim services, food, clothing, therapy, shelter, safety planning
Verity	835 Piner Road Santa Rosa, CA 95403	(707) 545-7270 Hotline: (707) 545-7273	Counseling, victim advocacy, accompaniments to court and SART exams, support groups

## **Appendix B: Resources for CSA Survivors in Marin County**

Table 2 Resources for CSA Survivors in Marin County

<b>Name</b>	<b>Address</b>	<b>Phone Number</b>	<b>Services</b>
Community Violence Solutions	30 N. San Pedro Rd, Suite 170 San Rafael, CA 94903	(415) 259-2850 Hotline: (800) 670-7273	Advocacy, education, counseling, self-defense classes
Jewish Family and Children Services	600 Fifth Ave San Rafael, CA 94901	(415) 419-3600	Counseling, food, case management, post-adoption help
Children and Family Services	3250 Kerner Blvd San Rafael, CA 94901	(415) 473-2200	Case management, therapy, emergency response for suspected abuse
Center for Domestic Peace	734 A Street San Rafael, CA 94901	Call/ Text: (415) 526-2557 Live Chat: <a href="http://www.loveisrespect.org/">http://www.loveisrespect.org/</a>	Safety planning, emergency shelter, legal protection

## **Appendix C: Resources for CSA Survivors in San Francisco County**

Table 3 Resources for CSA Survivors in San Francisco County

<b>Name</b>	<b>Address</b>	<b>Phone Number</b>	<b>Services</b>
Safe & Sound	1757 Waller Street San Francisco, CA 94117 & 3450 3 <sup>rd</sup> Street, Building 2, Suite 300, San Francisco, CA 94124	(415) 668-0494	Advocacy, safety education, strength- based counseling
SFWAR	3543 18 <sup>th</sup> Street #7 San Francisco, CA 94110	(415) 861-2024 Hotline: (415) 647- 7273	Peer counseling, support groups, medical and legal advocacy, referrals
The Women's Building	3543 18 <sup>th</sup> Street #8 San Francisco, CA 94110	(415) 431-1180	Legal help, referrals, family reunification, wellness
Asian Women's Shelter	3543 18 <sup>th</sup> Street #19 San Francisco, CA 94110	(415) 751-7110 Hotline: (877) 751- 0880	Emergency shelter, case management, referrals, language access to 26 Asian languages
Comprehensive Child Crisis Service	3801 3 <sup>rd</sup> Street San Francisco, CA 94124	(415) 970-3800	Multilingual therapy, counseling, crisis intervention,
Huckleberry Youth Programs	3450 Geary Blvd #107, San Francisco, CA 94118	(415) 668-2622	Crisis shelter, counseling, health care, crisis intervention, case management
Larkin Street Youth Services	134 Golden Gate Ave San Francisco, CA 94102	(415) 673-0911	Case management, therapy, medical care, housing, education

**Appendix D: Resources for CSA Survivors in Alameda County**

Table 4 Resources for CSA Survivors in Alameda County

<b>Name</b>	<b>Address</b>	<b>Phone Number</b>	<b>Services</b>
Bay Area Women Against Rape	470 27 <sup>th</sup> Street Oakland, CA 94612	(510) 845-7273	Advocacy, SART accompaniments, coaching, therapy,
Highland Sexual Assault Response Team	1411 E 31 <sup>st</sup> Street Oakland, CA 94602	Hotline: (510) 534-9290	Priority care from specialized medical providers
The Center for Child Protection	747 52 <sup>nd</sup> Street Oakland, CA 94609	(510) 428-3742	Medical and mental health services, forensic medical evaluations
Alameda County Family Justice Center	470 27 <sup>th</sup> Street Oakland, CA 94612	(510) 267-8800	Counseling, case management, restraining orders, trauma recovery, safety planning, shelter
Family Violence Law Center	470 27 <sup>th</sup> Street Oakland, CA 94612	(510) 208-0220	Child custody and visitation filings, restraining orders, housing legal needs, advocacy

**Appendix E: Resources for CSA Survivors in Contra Costa County**

Table 5 Resources for CSA Survivors in Contra Costa County

<b>Name</b>	<b>Address</b>	<b>Phone Number</b>	<b>Services</b>
Community Violence Solutions	2101 Van Ness Street San Pablo, CA 94806 & 301 W 10 <sup>th</sup> Street, Antioch, CA 94509	(510) 237-0113 & (925) 706-4290	Advocacy, education, counseling, self- defense classes
Bay Area Legal Aid	1025 Macdonald Ave Richmond, CA 94801	(510) 233-9954	Health care access, housing preservation, economic justice, advocacy
Victim Compensation Program	1025 Escobar Street Martinez, CA 94553	1 (800) 777-9229	Financial assistance for crime related expenses, crisis intervention, counseling
STAND! For Families Free of Violence	1410 Danzig Plaza Concord, CA 94520	(925) 676-2845 Hotline: (888) 215- 5555	Emergency shelter, emergency response team, court accompaniments, advocacy, assessment, therapy, case management