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# Dance/Movement Therapy Utilizing Therapy Dogs for Adults Diagnosed with Psychotic Disorders

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DANCE/MOVEMENT THERAPY UTILIZING THERAPY DOGS FOR ADULTS  
DIAGNOSED WITH PSYCHOTIC DISORDERS

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in

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## **Abstract**

The purpose of this project was to develop dance/movement therapy (DMT) interventions incorporating therapy dogs with the goal of increasing present moment awareness in adults diagnosed with psychotic disorders. Individual interviews were held with two therapy dog handlers who served as consultants for the purpose of obtaining information regarding therapy dogs and how they are used in sessions. These individual interviews were audio recorded and transcribed to inform the development of three DMT interventions in collaboration with the dog handlers. A version of the Delphi Method was utilized in order to systematically organize the data obtained from the interviews (Hsu & Sandford, 2007). After development and review of the interventions, an implementation trial was held. This implementation trial consisted of five dance/movement therapy students, the two consultants, one volunteer therapy dog handler, myself as the facilitator, and three therapy dogs. This implementation trial served the purpose of obtaining feedback to incorporate into the final development of the dance/movement therapy interventions utilizing therapy dogs.

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## **Chapter One: Introduction**

This thesis project originated from my love and passion for animals and the field of dance/movement therapy. As a young child, I did not have many social connections because I grew up in rural Ohio where there were few children my age living nearby, which left me feeling isolated. However, animals were always a constant presence in my life and my connections with them were indescribable. Connection with them provided opportunities for play, growth, and building relationship and connection. I remember camping with my dogs in my parents' backyard, eating breakfast on the front porch with two cats and two dogs surrounding me at all times, or even riding my bike while holding onto one leash in each hand with a dog on the end of both. My dogs were the first to greet me when I walked up our driveway from getting off the school bus, and they were the last ones I would say goodbye to when I left for the day. My parents could see my strong connection with animals, and thankfully, supported these relationships which is why we always had dogs, cats, guinea pigs, hamsters, fish, rabbits, gerbils, and even a frog or two.

My animals were my friends and supporters. Growing up as an introverted and shy child, I always felt that I could be myself around animals. There was something about simply having an animal near me, sitting together in the quiet, no words needing to be said, no judgement being made, no thoughts of anticipation for what to say or do next. Being in the present moment with another was the most powerful feeling of being fully comfortable with myself. As I grew older and enrolled in school, life became significantly busier. I joined dance groups and sports teams, and my circle of friends and social connections grew. My introversion and shyness started to dissipate and other parts of me began to come forward. However, through all of these changes within myself, I always returned back to the quiet moments with an animal and continue to do so

when life becomes overwhelming and stressful. Even small moments of laying and breathing together and being in the here and now help me find moments of peace, comfort, normalcy, happiness, stillness, calm, and recuperation.

Dance has also been a constant in my life; a creative outlet that offered a means of expression, creativity, and celebration, individually or as a shared process. This led me to research dance/movement therapy (DMT) after witnessing the power of movement and dance to affect positive emotional changes among residents in a nursing home setting. I enrolled in the graduate program at Columbia College Chicago, which led me to this thesis project. Dance, movement, and my love for working with people were all apparent in my life as a graduate student, but there needed to be more. I thought back to my relationship with animals and began to wonder if animals could be integrated into my professional life to fulfill my professional self as a working dance/movement therapy candidate.

Before I was a dance/movement therapy student at Columbia College Chicago, I had the opportunity to volunteer with a behavioral health hospital in Ohio. I worked primarily with individuals diagnosed with schizophrenia spectrum and other psychotic disorders. One of the primary features of these disorders is that individuals experience a disconnect from our shared reality (American Psychiatric Association [APA], 2013), and a consequence of that disconnect can be difficulty with interpersonal interactions (APA, 2013). I noticed my own desire to move toward these individuals in relationship, honoring that their reality may be different from my own. In these moments I was reminded of the support I received from animals when I was also struggling to connect interpersonally as a child. I started to become curious about how my own experiences of tranquility, understanding, and belonging while in relationship with animals could transfer to adults diagnosed with psychiatric disorders. Through dance and DMT I found similar

experiences of peace that I gained while in relationship with animals which was another driving factor to integrate my two passions of animals and DMT together.

This curiosity led me to a clinical field placement at an inpatient psychiatric hospital. During my field placement, I noticed the same relational disconnection happening between clients that I did back at the hospital in Ohio. Often this disconnect presented as a difficulty with awareness. Clients did not know each other's names, they seemed unaware of sharing space, and most importantly they seemed disconnected from the present moment. For the purpose of this thesis, present moment awareness (PMA; see Appendix A) is defined as a moment where patients are able to tolerate their psychotic symptoms in order to orient to person, time, and space. This involves clients noticing one another, and understanding who they are in relation to another and their environment. Although research supports DMT increasing PMA (Sandel et al., 1993), my hope is that therapy dogs may be an additional intervention to use with DMT to increase PMA for individuals with psychotic disorders. I wonder if the use of therapy dogs may help ease vulnerability that individuals may experience in relationship to using their bodies and movement to increase PMA.

### **Purpose of the Project**

The purpose of this thesis project was to develop three dance/movement therapy interventions incorporating therapy dogs with the goal of increasing PMA in adults diagnosed with psychotic disorders. Interventions were created through collaboration with two therapy dog handlers and designed for use in therapy settings such as psychiatric hospitals, behavioral health centers, outpatient, or inpatient residential facilities. I was drawn specifically to individuals diagnosed with psychotic disorders because of the struggle with PMA that comes along with experiencing symptoms like delusions and hallucinations. Although there are many

dance/movement therapy interventions that may be utilized for assisting individuals in entering present moment awareness (Sandel et al., 1993), I wondered if these could be expanded by the use of therapy dogs.

The use of imagery and symbolism are key elements that are utilized in a Chace approach (Sandel et al., 1993). Chace discovered that the use of imagery moves a client's experience from concrete thinking to more symbolic, abstract thinking. When a client is led through imagery, behavior and action transforms into symbolic communication, and this symbolic communication can be shared among group members, thus increasing PMA through awareness and communication with others (Sandel et al., 1993). Sandel and colleagues (1993) stated, "As images emerge from more deeply held levels, patients may become more aware of behaviors or feelings which they have not yet consciously experienced." Therapy dogs may be used as a tool to increase imagery and symbolism in clients to deepen their awareness and enhance their present moment experience. Fine (2015) found, through her work of utilizing therapy animals with various populations, that animals influence discussion regarding client's internalized emotions through providing comfort, trust, and safety (Fine, 2015). Therapy dogs may be used as a tool to help clients feel more comfortable and willing to be led through imagery and symbolism in the therapy setting to aid in increasing PMA.

Therapy dogs have been traditionally utilized for comfort and support for clients in psychiatric facilities as part of their treatment process (Chandler, 2017). My curiosity led me to the foundation of this support and comfort, which is PMA (Butler, 2004). Through using the therapy dog as an intervention to instill comfort and support, discussion may be held with clients in how they can carry these feelings over into their everyday lives. Chandler described the need for trust and relationship between therapy dog and client in order for clients to achieve their therapy goals

(Chandler, 2017). Chandler (2017) differentiated the *human-animal bond* ( see Appendix A) from the *client-therapy animal relationship* (see Appendix A). The human-animal bond describes the bond that occurs between a pet and their owner that involves an on-going relationship that is voluntary and benefits both sides (Tannenbaum, 1995). The client-therapy animal relationship is a social connection that is formed through the human-animal attachment process. “The therapy pet can facilitate the client’s exploration of interpersonal relational dynamics and move the client toward greater functionality in relationships (Chandler, 2017).

Zilcha-Mano et al. (2011) shared similar beliefs. They questioned if the therapy animal in the room fulfilled the role of an attachment figure, since the relationship with a therapy animal is restricted due to time and boundaries which differ from an owner to therapy animal. However, Chandler (2017) found that clients may benefit from experiencing and witnessing the human-animal bond that may occur between the therapist and their therapy animal, because this relationship demonstrates to clients what trust and relationship exemplify. Some therapists believe that trust and the establishment of relationship are key for enhancing a client’s treatment outcome (Yalom, 2005). The foundation for establishing trust and a *therapeutic relationship* (see Appendix A) may begin with maintaining PMA. This is why the potential for integrating therapy dogs into DMT interventions may be one step in deepening and developing the client’s experience of their treatment process.

In the current body of literature, there has been minimal use of DMT incorporating therapy dogs. This project offers a new approach to DMT through the integration of therapy dogs. My hope for this innovative project is that researchers and clinicians find this integrated approach useful and expand upon the interventions developed. I intend to build upon the use of integrating therapy dogs in the therapy setting as another in-road to connection with individuals

diagnosed with psychotic disorders. My hope is that such an approach will similarly aid other dance/movement therapists. This project follows guidelines of Animal-Assisted therapy (AAT) and its frameworks when working with adults diagnosed with schizophrenia and other psychotic disorders (Chandler, 2017). An AAT approach aligns with my humanistic/existential theoretical approach with slight influences from cognitive-behavioral and solution-focused therapy.

### **Theoretical Approach**

Ivey et al. (2012) explained that the humanistic-existential approach holds respect for individual clients and highlights the need for clients' relationships with others. Yalom (2005) captures this when discussing group therapy, stating that an indication of a strong, cohesive relationship in the therapy setting is the best outcome for treatment. This includes, but is not limited to, feeling understood by peers, sharing similar experiences as one's peers, and instilling hope in one another (Yalom, 2005). "Often the most effective antidote to demoralization is the presence of others who have recently been in similar straits and discovered a way out of despair" (Yalom, 2005, p. 109). Furthermore, in a group setting, the therapist influences communication patterns between group members, requiring a here and now approach to facilitation.

Within the humanistic-existential paradigm, existential components place value on clients being responsible for their own actions (Ivey et al., 2012). I found moments of this being shown during my time working on the inpatient unit. Inpatient hospitalization may challenge clients by confronting them with limitations such as being confined to close quarters on the milieu, remaining in one room for the majority of the day, hindering their ability to freely roam the hospital or inhale fresh air. Another challenge clients face in the inpatient setting is that external resources may be depleted; their support system has failed them or they failed to utilize their support system such as therapists, friends, and family. This approach can be empowering for

clients, especially when their external resources may have been depleted and they need to utilize more internal resources.

This humanistic approach is also reflected in the Chace methodology (Sandel, et al., 1993) that I incorporated in the intervention development. A Chace approach includes a clear beginning, middle, and end to a session, which may be helpful in orienting clients into the PMA. It begins with a warmup, which includes mirroring and expanding client's movement repertoire, developing the theme of the group, and *group rhythmic activity* (see Appendix A). The middle of the session, also known as theme development, involves further integration and understanding of the body by clients expanding beyond their movement preferences cued by the therapist. Theme development also includes clients recognizing and understanding their body language in relation to others, and clients being led through guided imagery and symbolism for deeper processing. Clients verbalizing their thoughts, feelings, and emotions throughout theme development are encouraged by the therapist (Levy, 2005). Lastly, the closure of the session involves coming together in a circle for shared movements, expression of self including thoughts, feelings, and emotions, and discussion of what occurred in the group (Levy, 2005). This approach felt fitting for this thesis project, because the structure of a Chace group, incorporation of group rhythmic activity, and emphasis on group cohesion can aid in increasing PMA (Sandel et. al., 1993).

The humanistic-existential paradigm holds similar values of solution-focused therapy, which is an approach used widely by animal-assisted therapists (Pichot & Coulter, 2007). Pichot and Coulter (2007) explained that in their therapy setting, they “spend [their] time building solutions and seeking to understand who the client is, how the client sees the world, and therefore what the client views as the most appropriate solution” (p. 28). Such an approach can support empowering clients, which may aid them in advancing their treatment process, and

accessing PMA. Like the Chace methodology, solution-focused therapy places an emphasis on symbolism. Walter and Peller (1992) believe that solution-focused therapy highlights the need for questioning client's problem to aid clients in identifying the solution needed to achieve success in their growth during treatment. This begins with the client identifying their goal for beginning treatment, identifying when their problem occurs, and finally asking, "If the problem were resolved, what would you be doing differently?" (Walter & Peller, 1992, p. xii). This question is important in solution-focused therapy because it guides the client to imagine what their life could be like if the problem were fixed, which begins with identifying a problem in the first place. If therapy dogs are integrated into solution-focused dance/movement therapy, clients may feel more comfortable and safe when identifying and resolving their problems (Fine, 2015).

Chandler (2017) also holds value to the use of solution-focused therapy while utilizing therapy dogs. Similar to Yalom (2005), Chandler finds that the therapeutic relationship holds great value in the outcome of a client's treatment goals. Chandler reports that solution-focused AAT techniques promote rapport in the therapeutic relationship and increase trust and safety in the therapy setting. Chandler (2017) stated, "With solution-focused counseling there is an emphasis on here-and-now situations rather than on the past, and client-therapy animal interactions can be helpful with clients' focus, attention, concentration, and skill building" (p.175). Relationships with therapy animals can provide opportunities for clients to practice new relational skills and find solutions that work best for them.

This project also drew upon cognitive behavioral therapy (CBT) The symptoms of psychotic disorders include a vast range of difficulties with cognitive, behavioral, emotional, and interpersonal functioning, which impact each individual differently (APA, 2013). A cognitive behavioral approach to treatment is fitting for this thesis project, because it has been proven to be

the most prominent and effective treatment for adults diagnosed with psychotic disorders (Turkington, Dudley, Warman, & Beck, 2006). Ivey and colleagues (2012) stated that CBT focuses on clients' behaviors and responses that are observable. CBT is based on the premise that clients are born as "blank slates," which means that all behavior is a result of the environment (Ivey et al., 2012). Behavior that is praised will have a greater chance of being repeated, and behavior that is negatively received is less likely to be repeated. (Ivey et al., 2012). Beck and colleagues agree that CBT can provide teaching moments for clients diagnosed with psychotic disorders. CBT can aid in monitoring negative and automatic cognitions, and recognizing connections in cognitions, affect, and behavior (Beck, et al., 1979). CBT, DMT, and PMA call for a present moment experience. It may be easier for the client to connect to the here and now if the therapist is able to describe their own observations of what is currently happening.

Integrating therapy dogs into a DMT setting is not only a passion of mine, but it is also supported through the literature that discusses the various ways in which DMT and therapy dogs can be utilized to address PMA with adults experiencing psychosis. The humanistic-existential and solution focused theories both call for empowering the client which deems fitting when integrating therapy dogs into DMT, since they are widely used as a support tool to aid in empowering and supporting clients through their treatment (Fine, 2015). Both theories, in addition to CBT, focus clients' present moment experience in order to work towards their therapy goals, through recognizing their problem and finding solutions to their situations.

## Chapter Two: Literature Review

This literature review examines the history, symptomology, and counseling approaches used as treatment for psychotic disorders. It also examines the importance of present moment awareness (PMA) when treating adults diagnosed with psychotic disorders. Further, it supports how Animal-Assisted Therapy (AAT), therapy dog use, and dance/movement therapy (DMT) could be utilized as means of treatment for adults diagnosed with psychotic disorders.

### History of Psychotic Disorders

The first written description of schizophrenia was given by John Haslam in 1810 from the Bethlem Hospital in London. Haslam described a patient who seemed to suffer from delusional symptoms (Carpenter, 1989). Around fifty years later, Benedict Morel, a Belgian psychiatrist, reported psychotic symptoms from one of his patients who was a thirteen-year-old boy (Butcher, Mineka, & Hooley, 2013). Morel reported that this once brilliant, driven boy seemed to lose cognitive abilities such as memory and physical executive functioning and became increasingly lethargic, withdrawn, isolated, and silent.

Using the Latin version of Morel's term, *dementia praecox*, Kraepelin described a patient who appeared weary of others surrounding him, believed his food was poisoned, feared the police were following him, and thought his body was being influenced from exterior forces (Butcher, Mineka, & Hooley, 2013). Then, in 1911, Swiss psychiatrist Eugen Bleuler coined the term schizophrenia which comes from the Greek roots of *schizo* meaning to split or crack, and *phren*, meaning the mind (Butcher, Mineka, & Hooley, 2013). "...He believed the condition was characterized primarily by disorganization of thought processes, a lack of coherence between thought and emotion, and an inward orientation away (split off) from reality" (Butcher, Mineka & Hooley, 2013, p. 453).

Although the history and symptomology of schizophrenia and other psychotic disorders has been documented for hundreds of years, relapse remains high. According to Reichenberg and Seligman (2016), approximately 50% of people hospitalized with schizophrenia will experience relapse within two years of their first episode, and around 78% of people will relapse within five years of their first episode. Deterioration of the brain and personality tend to progress over time, increasing after each relapse (Reichenberg & Seligman, 2016). This thesis project may be one contributing element in aiding relapse prevention in adults diagnosed with psychotic disorders, as well as contributing to the wealth of knowledge when treating these individuals.

### **Symptomology of Psychotic Disorders**

The DSM-5 describes psychotic disorders as having several key features:

Schizophrenia spectrum and other psychotic disorders include schizophrenia, other psychotic disorders, and schizotypal (personality) disorder. They are defined by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms (American Psychiatric Association [APA], 2013, p. 87).

Delusions are fixed beliefs that individuals are unable to change, even with reality-based evidence (APA, 2013). Hallucinations are involuntary, vivid, and clear experiences that occur without external stimuli. When individuals experience hallucinations, they appear and feel real (APA, 2013). Disorganized speech may include: loose association where the individual may quickly switch between topics, tangential speech where the individual may respond to a stimulus that is completely unrelated, or incoherence where the individual's speech is so disorganized that their sentencings does not make sense to another (APA, 2013). Grossly disorganized or abnormal

motor behavior has a wide range of symptoms which can include unforeseeable frustration, silliness, outbursts, and involuntary movements (APA, 2013). Lastly, negative symptoms, such as flat affect and avolition are commonly associated with schizophrenia, but are less common in the other psychotic disorders. Flat affect is where the individual may show little to no emotion. Avolition means that the individual shows decreased activity, which may look like laziness; however, the individual could be still for hours upon hours and exhibit minimal interest in joining activities (APA, 2013).

### **Treatment of Psychotic Disorders**

Medications and psychosocial interventions are currently being used in the treatment of schizophrenia and other psychotic disorders (Caponigro et al., 2014). Antipsychotic medications are utilized to aid in reducing some positive symptoms of schizophrenia; however, these medications are less effective in reducing negative symptoms (Caponigro et al., 2014). While the treatment of schizophrenia has improved significantly over time, many therapists believe there is room for greater improvement, more specifically, involving client's emotional well-being.

Chien and researchers (2013) created a literature review to identify the most used therapy approaches and psychosocial interventions used for individuals diagnosed with schizophrenia. They found the most common forms of treatment are psychoeducation, family intervention, CBT and cognitive remediation therapy, and assertive community treatment (Chien et al., 2013). Psychosocial interventions have been shown to effectively relieve clients' psychotic symptoms while improving their functionality in their day to day living (Chien et al., 2013). However, evidence supporting long term treatment of schizophrenia is lacking. Chien and colleagues call for improvement of future treatment strategies focusing on identifying risks in client's behavior, early treatment assessment, the use of person-centered therapy, establishment and use of client's

support systems, and combining evidenced-based psychosocial interventions into services already in place (2013).

Meditation practices have been an effective technique used in treatment for adults diagnosed with psychotic disorders in maintaining PMA (Shonin, Gordon, & Griffiths, 2013). Specifically, concentration meditation involves bringing one's focus to a single point. Each time the mind wanders, individuals are cued to bring their awareness to the wandering thoughts, let them diminish, and bring attention back to the object (Gaiam, 2018). Practicing the process of concentration meditation improves one's ability to concentrate, thus, improving the ability to increase PMA (Gaiam, 2018). "...The goal of meditation is no goal. It's simply to be present" (Gaiam, 2018).

A study conducted by Johnson and colleagues (2011), focused on clients emotional well-being. Participants with schizophrenia attended six meditation sessions focused on love and kindness. Participants reported a reduction of their negative symptoms and an increase in overall satisfaction with their lives, self-acceptance, and positive, optimistic emotions (Johnson et al., 2011). Another study completed by Louise, Russell, and Thomas aimed at finding the potential benefits of utilizing mindfulness-based interventions for adults experiencing auditory hallucinations (2018). Participants included 14 adults diagnosed with schizophrenia spectrum and other psychotic disorders. They completed pre and post-intervention tests that measured levels of engagement in the sessions, frequency of auditory hallucinations, frequency of feeling distracted, and levels of depressive symptoms. After four weeks of practicing the Mindfulness Program for Voices, results indicated that participants experienced high levels of engagement, and reduction of auditory hallucinations, depressive symptoms, and distractions (Louise, Russell, & Thomas, 2011). Similarly, Laithwaite and colleagues (2009) conducted a study on adults in

high security facilities that involved compassion-focused therapy where treatment focused on self-compassion. Results indicated that clients showed reduction of their depressive and psychotic symptoms, and notable improvements of their self-esteem.

Caporigo and researchers (2014) concluded that individuals living with schizophrenia experience similar positive emotions as someone who does not have schizophrenia and appear to benefit from interventions that are specific to enhancing overall well-being. In their study, they wanted to find if clients diagnosed with schizophrenia or schizoaffective disorder would be motivated to attend a group focused on emotions, and if they would partake in the skills learned in the group. Caporigo and colleagues used the intervention Awareness and Coping with Emotion in Schizophrenia (ACES) which was developed by Moskowitz and colleagues (2011). This intervention uses a CBT approach with a skills-based style. Participants of this study were adults ages 18-60 who attended six, 90 minute sessions where they learned eight CBT skills proven to increase well-being in individuals diagnosed with schizophrenia or schizoaffective disorder (Caporigo et al., 2014; Moskowitz, 2010). Results indicated that participants who regularly attended the well-being group showed interest and engagement in it, and the majority of participants practiced the skills learned in group, which were reported to be moderately to highly beneficial (Caporigo et al., 2014).

Dixon and researchers (2016) have found person-centered care as a successful approach to treatment for adults diagnosed with psychotic disorders. Person-centered care emphasizes that each client's goals and life experiences are unique, and involves a sharing of decisions regarding their treatment plan (Dixon, Holoshitz, & Nossel, 2016). They identified that young adults who have already experienced their first psychotic episode are harder to engage in treatment. Without psychoeducation on the benefits of seeking treatment for psychotic disorders, relapse and re-

hospitalization are more likely to occur (Dixon, Holoshitz, & Nossel, 2016). In order to engage and maintain clients in treatment, Dixon and colleagues (2016) call for newer treatment strategies, including the use of electronics and technology, peer providers, and the Cultural Formulation Interview - a system used to provide insight into each client's unique, cultural background utilizing person-centered care. Similar to Yalom (2005), and Reichenberg and Seligman (2016), Dixon and colleagues (2016) call for the development of the therapeutic relationship as an in-road to successful treatment for adults diagnosed with psychotic disorders.

Reichenberg and Seligman (2016) described that early assessment and treatment is best when treating schizophrenia and other psychotic disorders. They highlight a CBT approach in which the therapist role should portray optimism and warmth, but also be direct and consistent. Once a therapeutic relationship is established, small doses of reality testing aids clients in addressing delusional beliefs. Therapists who use CBT for people experiencing delusions should utilize interventions that aim at the trigger for the delusional belief rather than the actual delusions themselves (Reichenberg & Seligman, 2016). As cited in Waller and colleagues, a study was conducted by O'Conner and colleagues where CBT was found to aid in reducing how strongly clients experienced the delusions and diminishing thoughts of worry and anticipation (Waller, Freeman, Jolley, Dunn, & Garety, 2011). However, while surveys of CBT have shown it to be a helpful framework for treatment, there is little evidence of its effectiveness in long term treatment (Reichenberg & Seligman, 2016).

**Therapy animals aiding treatment.** Strategies for long-term treatment of psychotic disorders is lacking; perhaps the integration of therapy animals in the treatment setting is one in-road to the maintenance and success of treatment (Chandler, 2017). There is a large amount of research that explains why the use of animals enhances a person's experience, not only in the

therapy setting, but in a variety of contexts (i.e. Chandler, 2017; Fine, 2015; & Wesley, 2007). In his dissertation, Wesley (2007) wrote, “Domesticated animals have played a significant role in the lives of humans for thousands of years” ( p. 9). As cited in Wesley, Cantanzaro described how the people of Gheel, Belgium in the ninth century utilized animals as uplifting tools while providing care for people with disabilities (Wesley, 2007). The first written record about animals in the therapy setting was the York Retreat for the Differently Abled Minds in the late 1700s where animals were utilized to provide comfort to the patients (Tuke, 1964). In a time when most people with a disability or mental illness were admitted to asylums, which engaged in the use of harsh punishments and mistreatment, animals were used instead to aid patients in becoming more oriented and reality- based (McCulloch, 1986; Wesley, 2007). Today, animal assisted therapy is a formalized approach to clinical mental health treatment.

Boris Levinson was the first to coin the term pet therapy. Working as a therapist, he brought his dog, Jingles, into his therapy sessions at a residential treatment facility and noted tremendous improvements in his adult clients with various diagnoses, such as anxiety reduction, social expansion, and behavioral improvements (Levinson, 1964). His experience of pet therapy served as a potential for AAT. The first documentation of AAT occurred in Washington D.C. at St. Elizabeth’s Hospital. In 1919, Franklin Lane, the Secretary of Interior, suggested using dogs with psychiatric patients in their therapy settings (Hooker, Freeman, & Stewart, 2002). As far back as 1867, a treatment facility in Bethel, Germany invited various animals such as cats, birds, horses, and dogs, for patients to care for and interact with them (Wesley, 2007). The animals had a positive effect on the patients such as increasing their motivation, increasing their desire for more connection, and increasing their overall well-being. (Netting, Wilson, & New, 1987; Wesley, 2007). An additional use of therapy animals occurred at Pawling Air Force

Convalescent Hospital (Davis, 1988). Several animals were used in World War II to motivate those serving to partake in therapy and enhance the therapeutic relationship as they recuperated from both physical and emotional trauma (Davis, 1988).

Chandler (2017) describes animal-assisted therapy (AAT) as a tool used in an existing therapy setting where the therapist is able to use the therapy animal in the clinical lens they already utilize. It can be used in group therapy or individual therapy settings and can be utilized among various participants, including all ages and varying abilities. AAT is a goal-directed therapy that can play a part in the individual's treatment plan. Therapy dog handlers and their therapy animals have to be screened, properly trained, and pass various tests and retests. In order for the work to be considered AAT, the therapist must be credentialed, therapeutic goals are to be developed, and the therapist is expected to facilitate interactions between therapy animals and clients, observe and document progress toward goals, and to offer process commentary in sessions (Chandler, 2017). A few common goals for individuals working with therapy dogs are: improving social skills, learning appropriate touch, improving ability to trust another, addressing grief and loss, reducing anxiety, and improving concentration and attention (Chandler, 2017).

Furthermore, Chandler (2017) stated that social connections are necessary for survival and the use of therapy animals may be one inroad to achieving social connection. It has been found that after a couple minutes of a positive interaction with a dog, levels of oxytocin, endorphins, and dopamine rise significantly in both the dog and human (Chandler, 2017; Odendall & Meintjes, 2003). Chandler (2017) reported that oxytocin releases in the brain during times of relationship building and social bonding. Similar rises in oxytocin can be found in mothers who are breastfeeding, which stimulates emotional bonding between mother and baby (Uvans-Moberg, 2010). Due to its pleasurable properties, it creates a reward system in our brains

when we develop these connections. Chandler continues, “Research confirms that the oxytocin molecule and its effects are the same in all mammals (Uvnas-Moberg, 2010); thus, mammals are drawn to make contact with other beings perceived as sources for nurturance. This is part of mammals’ innate thrive biology” (Chandler, 2017, p. 9). This is one theory as to why many humans are drawn to interactions with animals. This supports why integrating therapy dogs into DMT could be one way of increasing present moment awareness in adults diagnosed with psychotic disorders. PMA can aid in the establishment of relationship. Due to the non-judgmental nature of therapy animals, clients are able to let go of self-expectations like perfection and co-occurring self-doubt. This allows for an ability to become present with the developing relationship with the therapy animal in the here and now (Chandler, 2017).

AAT is an invitation to look deeply, to ponder, and then let the doing come out of the activity. Participants can forget about limitations and expectations and enter into a challenge of achievement for self, practice without dwelling on the outcome, and focus on the experience itself. Being mindful is not about doing it perfectly, but about doing it the best one can at that moment, even if it isn’t about “perfect” by others’ standards. AAT is about being able to acknowledge accomplishment and to come away from that experience with something that helps the individual to try in a different, perhaps better, way (Lind, 2009, p. 8).

AAT’s success stems from the distinct bond created between animal and human through a non-hierarchical relationship that does not involve judgement, expectation, or stigma against the participant’s abilities (Lind, 2009). Furthermore, a participant’s motivation of completing activities of daily living may be achieved with a greater outcome through the use of therapy dogs (Lind, 2009).

By simulating daily living skills like feeding, getting dressed and cleaning up with the partner and making close approximations of the daily task, the participant will continue to practice over and over with the dog. With each success comes increased self-confidence and determination to succeed. These achievements can literally “jump start” the completion of these tasks with past frustrations, but now associates them with the games successfully played with basic tasks with the dog, the transference of these new skills to everyday life becomes much easier. (Lind, 2009, p. 73)

A connection can be made between increasing PMA and one’s ability to successfully attend to their daily needs.

Jasperson (2010), a clinician who specialized in working with female inmates, conducted a study that supports the benefits of AAT for adults diagnosed with psychotic disorders. Group participants consisted of five women, aged 26-42, who resided in the inpatient program at the Utah State Prison. Diagnoses included schizophrenia, major depressive disorder, schizo-affective disorder, and bipolar disorder. In addition to the inpatient residents, groups included a facilitator, a therapy dog handler, and one certified therapy dog. Eight group sessions were held once a week for one hour in which the facilitator utilized the therapy dog as a model for inmates’ development of relationship. Jasperson (2010) used the example of boundaries and invited group participants to recognize the dogs’ needs for boundaries, what that looks like, and how the boundaries are communicated by the dog. This led to discussion on all aspects of boundaries and their importance in human to human relationship.

After the last session with the dog, inmates reported a significant decrease in anxiety, depression, and social isolation, as well as an increase in positive social behaviors (Jasperson,

2010). Inmates also reported feelings of excitement and anticipation for their weekly groups with the animal. Jaspersen (2010) stated:

The goal of this group experience is to use the dog as a secure base, helping manage distress, and allowing participants to be open and receptive to the therapeutic value of the group experience. The theory is that participants will use the human-animal relationship to challenge their maladaptive coping strategies developed through their negative internal representations of self. (p. 426)

Similarly, Barker and Dawson (1998) wanted to explore how AAT may produce change in individuals living with psychotic disorders. They conducted a study on 230 psychiatric patients to test for a decrease in their anxiety levels by attending one animal-assisted therapy session. The patients completed a State-Trait Anxiety Inventory to self-report their current state of anxiety. The inventory was given before and after the animal-assisted therapy session. Results showed a reduction in anxiety scores after attending the AAT session. Through the use of AAT, the reduction of co-occurring symptoms in those diagnosed with psychotic disorders may be one way of achieving PMA.

In another study conducted by Barak and colleagues (2001), older adult patients diagnosed with schizophrenia attended weekly three-hour AAT sessions, in these sessions, treatment was focused on increasing communication, mobility, and personal hygiene. Therapy dogs and cats were used as support companions through the treatment process. The control group consisted of patients who attended discussion groups but did not attend AAT. Results indicated that those patients who attended the AAT session were found to have enhanced communication and socialization, increased use of activities of daily living, and overall a higher sense of well-being (Barak et al., 2001). Achieving PMA may support individuals in optimally reaching such

treatment outcomes. This is one reason why utilizing therapy dogs in a DMT setting could increase a client's ability to achieve present moment awareness.

**Dance/movement therapy.** An effective treatment modality for adults diagnosed with schizophrenia and other psychotic disorders is DMT (Sandel et al., 1993). In her work with patients diagnosed with psychotic disorders, Chace utilized group rhythmic activity in her DMT groups (Sandel et. al., 1993). When not oriented to the present moment, patients experiencing psychosis may have difficulty relating to others. A common goal in DMT is to create or enhance a sense of self as well as the ability to relate to another (Sandel et. al., 1993). One way of establishing this felt sense of self and relationship is through the use of dance and creating a shared rhythm as a community. Being a part of a communal, unified rhythm and actively engaging in a shared movement with a group can provide an increased sense of self, feelings of enlivening, and a greater flow of energy throughout the self and the group (Sandel et al., 1993).

Chaiklin and Wengrower agree that rhythm is a practical part of a DMT session, because it is seen as a means of communication between client and therapist, and client to client interactions (2009). They stated,

There is some undefined sense of satisfaction that is felt when a group of discordant and isolative patients becomes unified through synchronized rhythmic movement. Often, psychiatric patients exhibit arrhythmic movement patterns, the element of rhythm being impaired, undeveloped, or inhibited. Movement patterns within the DMT session provide rhythmic experiences that foster communication and relationship.

The therapist can introduce rhythm externally such as using tools like instruments, vocal patterns, or music, or internally such as heartbeat, and breath (Chaiklin & Wengrower, 2009).

The combination of both external and internal rhythms may provide a richer, all-encompassing

chance for clients to make a decision, create, and express. Rhythm can help organize and provide structure to the disorganized internal and external experience that is often a part of the reality of those diagnosed with psychotic disorders. “Through moving in unison in a particular rhythmic relationship, patients can find both comfort and success being in the ‘here and now’ of the session” (Chaiklin & Wengrower, 2009, p. 94) Capello (2009) also stated that sharing group rhythms can promote group cohesion, bring energy into a sluggish group, and provide a rich closure to the DMT session.

Similar to Chaiklin and Wengrower’s beliefs on the positive influence of dance/movement therapy on adults with psychotic disorders, Lee and colleagues conducted a study on the effects DMT has on affect and psychotic symptoms in patients with schizophrenia and found similar benefits (2015). They tested a group of adults diagnosed with schizophrenia where one group received medical treatment and DMT, while the control group received only medical treatment for over 12 weeks. In the group who received DMT with medical treatment, patients showed a significant decrease in anger and depressive symptoms, and a significant decrease of negative psychotic symptoms compared to the control group. This supports the rationale for the use of DMT as treatment for adults diagnosed with psychotic disorders to bring awareness to client’s emotional state which increases PMA (Chaiklin & Wengrower, 2009).

Condon’s (1968) research on interactional synchrony also holds value to the use of DMT. This research showed that an individual’s movements are synonymous with the movement, tone, and speech of the person verbally speaking. This research supports DMT in that this therapy modality may aid in reestablishing and integrating communication through the body, which may assist clients in deeper connections in a group therapy setting (Condon, 1968). This concept of synchrony was utilized in Chace groups in order to promote a sense of cohesion in the group. In

her groups, Chace reported that movement that was unified led patients to feel more comfortable in the therapy setting, as evidenced by relaxed body postures, laughter, and patients speaking more freely and openly (Sandel et al., 1993).

Imagery and symbolism are key concepts used in Chace's approach. When clients try on or mirror one another's movements they are connecting, or becoming present with one another. Sandel and colleagues (1993) provide an example of hospitalized adult patients connecting through clapping their hands to the beat of the music being played in a DMT session. When cued by the therapist, one client described their clapping movements as making pizza dough. Soon, other group members embarked on this imaginative journey, which developed into ingredients needed for their pizza, which evoked more movements coming from the clients. This developed into the idea of a pizza party where clients were asked to share who would be invited to the pizza party. One client expressed fear that no one would come to the pizza party. This statement emerged from the client's experience of having no friends or family visit them while in the hospital during their treatment. This led to group processing feelings of loneliness, fear, and rejection, which allowed clients to connect more deeply with one another in this shared experience (Sandel et al., 1993). Sandel and colleagues (1993) also suggest that differences in establishing or processing imagery in the group is noteworthy. Not all group members will respond to an image the same way, so recognizing polarities of emotions tied to the imagery can diminish guilt that some clients may experience with intense reactions which can be just as important as a cohesive imagery experience.

Chace was highly influenced by American psychiatrist, Harry Stack Sullivan, who was known for his work with individuals diagnosed with schizophrenia. His work emphasized that each individual is unique, worthy of interpersonal interactions, and deserves to be treated with

respect and empathy (Levy, 2005). Chace aligned with this theory and found DMT to be a deepening inroad to connection with those diagnosed with psychotic disorders. Chace picked up on both the verbal and nonverbal communication of her clients. Levy reported,

It was Chace's profound ability to use dance movement for self-expression and communication and her capacity to perceive, encounter, reflect, and interact with the movement expressions of her patients that enabled her to draw them out of their psychotic isolation (Levy, 2005, p. 21).

Thus, DMT is an effective treatment for individuals diagnosed with psychotic disorders.

Similar to Chace, dance/movement therapist Ann Lohn (1993), explained how the use of rhythm brought together a group of women diagnosed with psychotic disorders and helped them find cohesion in session. Lohn explained that one woman in this group was particularly resistant to DMT and walked away from the group to stand near a window. As the group continued, there was a request to change the music that was playing and Lohn suggested that the group make their own rhythm and music. The woman who sat by the window for the majority of the group reentered the therapy session and led the group in a song. Soon after, the other women in the group began singing and clapping their hands to a synchronized beat. Lohn reported that not only did the group finally come together in cohesion, but movements became more expressive in all of the women, and once the group concluded, Lohn described their affect and energy to look brighter and invigorated (Sandel et. al., 1993; Stark & Lohn, 1989). This is another example of how the use of rhythm in a DMT setting can bring a group into the here and now to achieve cohesion, aiding their treatment.

Levy (2005) provided a case study of a thirty-year-old woman who showed symptoms of somatic delusions as a result of years of sexual repression. Through the use of movement,

imagery, and the verbalization of frustrations and feelings of guilt, the client was able to begin the process of expressing her experience of sexual repression. She eventually came to a feeling of acceptance and went on to write short stories about her experience, laugh about it, and eventually heal (Levy 2005). It was because of DMT that the client was able to take her symbolic world, which even she could not fully understand, into movement and creativity to find an outlet for expressing and healing. Levy met her client in her experience and brought her into a deeper understanding of it in a very gentle, empathic way.

Drama therapist Johnson and dance/movement therapist Sandel (1977) conducted much of their research in inpatient psychiatric facilities. They devised a system used as a tool for analyzing the structure and functioning of a DMT group called the Structural Analysis of Movement Sessions (SAMS). It was originally devised for the therapist to use as a tool to further develop their interventions. They conducted a study on three different groups: individuals diagnosed with schizophrenia, individuals diagnosed with personality disorders, and individuals classified as the norm. Three dance/movement therapists lead two sessions: one session was very differentiated with rules and order, and one session was less differentiated, using movements that were occurring in the present moment, and imagery. These sessions were videotaped and analyzed using the SAMS method. Results indicated that the group of individuals diagnosed with schizophrenia responded better to the second group, which was less differentiated and focused more on the present moment. In the highly structured group, clients experienced confusion due to the large number of rules (Johnson & Sandel, 1977).

Present moment awareness is a reoccurring theme in DMT groups for adults diagnosed with psychotic disorders. It has been observed in groups by Chace, Lohn, and Sandel and Johnson who have provided examples and case studies of its importance when working with

these individuals. Through the use of rhythm, sensory stimuli, imagery, symbolism, and music, present moment awareness can be achieved which may foster a deeper, more successful healing process for an individual diagnosed with psychotic disorders (Johnson & Sandel, 1977; Sandel et. al., 1993).

While DMT is effective in helping adults with psychotic disorders orient to the present moment (Sandel et al, 1993), there is little literature support on the integration of therapy dogs into DMT. Pamela Slane's (2015) dissertation, *Dance/Movement Therapy and Animal Assisted Therapy with Adolescents in a Residential Treatment Setting*, likely contains highly relevant information for this thesis, but it was unavailable as of this writing. However, in a series of interviews completed by Ford (2013), it was found that there are some major bridges between equine-facilitated psychotherapy (EFP) and DMT. The horses served as mirrors of clients' emotions; facilitated nonverbal communication, embodiment, and congruence; increased mindfulness in clients and their awareness of space, body, breath, movement, relationship, and community; and increased creative expression, touch, and support (Ford, 2013). Those interviewed also expressed that horses strengthened the therapeutic relationship.

**Group therapy.** Yalom (2005) highlighted the benefits of a group therapy setting. He expressed the development of social skills; feelings of belonging, empathy, and universality are all positive items that can grow from clients participating in group therapy. Yalom reported that group therapists are highly influential towards their clients regarding communication patterns that occur between group members, and calls for a here and now approach to facilitation. The therapist serves as a model for behaviors such as support, self-disclosure, and healthy communication styles (Yalom, 2005). Yalom (2005) observed that individuals who attend long-term group therapy have shown improvements in attunement, empathy expression, non-

judgment, and conflict resolution with group members. Orenstein (2018) agrees with the benefits of group therapy. She reported that group therapy can offer support and a sounding board- meaning group members may provide insight the individual could not see before (Orenstein, 2018). Group therapy can also accelerate motivation for treatment. Listening to the success of others may be encouraging for other group members to hear. Orenstein (2018) states that group therapy can aid in the promotion of social skills through engagement with one another, and points out that group therapy tends to be less costly than individual therapy.

There is much research that supports treatment for adults with psychotic disorders including AAT, DMT, meditation practices, CBT, person-centered care, and group therapy. While there is much research for this population, literature is lacking in the integration of DMT and AAT. This literature review served the purpose of linking the two treatment approaches in the hopes of expanding upon interventions to increase present moment awareness in adults with psychosis.

### **Chapter Three: Intervention Development**

Three interventions using therapy dogs in combination with dance/movement therapy were developed in collaboration with two therapy dog handlers to increase PMA in adults with psychotic disorders. The interventions were designed to be used with individuals in outpatient or inpatient psychiatric facilities. For the future, dance/movement therapists may use these interventions to expand upon their own practice by incorporating therapy dogs in the therapy setting for adults diagnosed with psychotic disorders. The hope for this thesis project is that it could eventually influence the development of evidence-based programs where observable behavioral change related to increasing PMA is documented and assessed through scientific means.

An adaptation of the Delphi method was used for the purpose of gathering and synthesizing information obtained from the collaborators. Individual interviews were held with the dog handlers, during which we discussed the benefits and limitations of using therapy dogs, how they utilize therapy dogs in their work, and case examples of individuals interacting with their therapy dogs. This feedback was recorded and transcribed, which aided in the development of the interventions which were then reviewed and tested on five DMT peers during an implementation trial. Their feedback was video recorded and transcribed which aided in the final results of the interventions.

#### **Delphi Method**

Hsu and Sandford (2007) explained the Delphi method as a flexible and easily adaptable tool for gathering information for a specific topic that needs further development. Because so little information exists on the incorporation of therapy dogs into dance/movement therapy sessions, the Delphi method seemed to support this thesis project. The structure of the Delphi

method served as an aid for organizing and synthesizing information gathered through three in-person meetings and one clarifying phone call with each consultant. Although the Delphi method is typically used to identify group consensus across a large range of disciplines, I found it helpful to find patterns between my work as an emerging dance/movement therapist and the consultants' work as therapy dog handlers.

The three in-person individual interviews were recorded through a voice recording app on my phone, which was locked under a password protected file. After the interviews were recorded, they were reviewed and typed into a written transcript by pausing the audio recorder to allow time for typing, and re-listening to the audios to track any connections or information being shared that resonated with me. These transcripts were saved under a password protected file on my personal computer. As I reviewed the written text, I underlined items that resonated with me, connected to DMT, provided information about their work with therapy dogs, or had the potential to inform the interventions. Topics that were similar across interviews with each consultant were circled and later served as a guide for the final development of the three interventions. Once the interventions were developed, two individual phone calls were held for the purpose of clarifying the interventions, discussing the roles of the consultants for the implementation trial, and identifying potential scenarios that might occur in the implementation trial.

### **Collaborators**

Two certified therapy dog handlers were selected to serve as consultants for this project to aid in the intervention development and to attend and assist in the implementation trial (see Appendix C). One volunteer therapy dog handler also attended the implementation trial to handle one of Consultant B's therapy dogs, and provide support and guidance to peers during the

implementation trial (see Appendix D). Five dance/movement therapy students attended the implementation trial for the purpose of providing feedback regarding the interventions (see Appendix E).

**Therapy dog handlers.** Consultants were chosen based on their experience working with adults diagnosed with psychotic disorders, and if they currently owned or were working with a therapy dog. At least twenty initial emails were sent to various therapy dog handlers that were found through online research. These emails briefly explained the purpose of this thesis project, the desire for an open, collaborative process, the required time frame for multiple interviews, and the execution of the implementation trial. Due to an inability to find collaborators in my first round of emails, I expanded my inclusion criteria and broadened my search from animal-assisted therapists to therapy dog handlers with experience working with adults diagnosed with psychotic disorders. The second round of emails resulted in two individuals interested in collaboration. Consultant A is a recreation therapist, employed by her current facility for over 9 months. Consultant B holds a high level position at a local organization which connects therapy dogs and their handlers with various therapeutic organizations.

**Peers.** Six dance/movement therapy students were emailed to participate in the implementation trial, and five of the six agreed to participate. These peers were chosen due to experience working with adults diagnosed with psychotic disorders, whether that was through their work at internship sites or volunteering. Students were informed in the initial email that three therapy dogs would be working alongside them in three interventions led by myself and three therapy dog handlers. They were informed that these interventions were not simulated sessions, but that they would be participating as themselves while keeping a case study or example of a patient in mind. Peers were informed that their participation was to serve the

purpose of testing these interventions on them in order to offer feedback, including how these interventions may increase and/or maintain PMA for adults diagnosed with psychotic disorders, how the use of therapy dogs may be incorporated into DMT sessions, how the interventions might look in an inpatient or outpatient setting, and any suggestions for future work with these interventions.

## **Procedure**

A total of five meetings were held in a progressive order. First, I conducted three individual, two-hour information gathering interviews with each consultant, one clarification phone call with each consultant, and one final meeting with the two consultants, three therapy dogs, and five dance/movement therapy students for an implementation trial. Semi-structured interviews began with a series of questions that were developed prior to meetings with the consultants (see Appendix B), but flexibility was allowed to establish a natural conversation. Unlike the traditional Delphi method where multiple rounds of questionnaires are given independently, this flexible structure provided space for open-ended questions and conversations. The initial interview questions were established ahead of time, but more questions were asked pertaining to their responses. Therefore, a more natural conversation was able to occur through a semi-structured interview. Questions were designed to gather information regarding their professional experience including: history of working with adults experiencing psychosis, training, theoretical framework, certifications, and how they began working with therapy dogs. This informed questions that guided conversations in the second and third interviews, which were more focused on similarities and differences between their work with therapy dogs and DMT. The nature of each meeting is described below.

**Meeting 1.** The initial meeting with Consultant A occurred in her office at her place of employment, and initial interview questions (see Appendix B) were brought to this meeting. The purpose of this meeting was focused on sharing our background information with one another. This dialogue occurred with open discussion on her background, work history, beginnings of her career with her therapy dog, and how her therapy groups typically incorporate her dog. She also shared some examples of her groups, client interactions, and observations for how beneficial therapy dogs can be in a therapy setting. I briefly shared information on DMT, including my personal approach and my experience in the field as a student. This first meeting concluded with establishing when we would have our next meeting.

After a few days of incubating this information, I typed the recorded interview into a transcript to reference back at any point during this thesis process. Once this initial transcript was completed, I reviewed it, and aspects that resonated with me or appeared of importance for the establishment of PMA interventions were underlined. I put this aside to be reviewed again after the first interview with Consultant B.

The first interview with Consultant B occurred similarly to that of Consultant A. This meeting occurred in her office of her place of employment and the same questions were brought for the purpose of establishing a relationship that could further develop into our work together in finding how therapy dogs could be integrated into DMT interventions. This initial interview was transcribed in a similar fashion, underlining portions that might contribute to the final product of integrating therapy dogs into DMT interventions. Utilizing a modified version of the Delphi method, these transcriptions were reviewed simultaneously. Portions that aligned or had similarities were highlighted, as well as portions that differed from one another. These

similarities and differences allowed for ideas and questions that could be taken to the second interview with each of the consultants.

**Meeting 2.** The second meeting with Consultant A took place in her home and focused on the importance of PMA in animal assisted therapy and DMT. She shared how PMA is incorporated into her groups, including several examples of how she has observed PMA to be the underlying need when working with a therapy dog. She offered several case examples of how beneficial increasing PMA is for patients diagnosed with psychotic disorders in therapy settings as it often carries over into the patient's life outside of treatment.

The cases Consultant A shared connected to my own experience attempting to increase PMA as a dance/movement therapist with individuals with psychotic disorders. I shared two examples of dance/movement therapy interventions with Consultant A and we discussed how they could be reworked to incorporate therapy dogs (see Chapter 5 for additional details). Finally, this meeting concluded with a focus on how we approached our work specific to adults diagnosed with psychiatric disorders within our settings, including how we address the goal of PMA and which interventions have been successful and which have not. Cultural considerations were also discussed as related to Consultant A's approach to using therapy dogs in her work as well as my approach to DMT.

The second meeting with Consultant B was similar to the meeting with Consultant A. The same questions developed ahead of the interview (see Appendix B) were used in the second meeting with Consultant B. Overall, the focus of this second meeting was the importance of PMA, including how she defined PMA, what is important about PMA in her groups, techniques used with the therapy dog to achieve PMA, and any other cultural considerations with PMA and therapy dogs. This is described in further detail in Chapter 5.

I also brought a few ideas that Consultant A and I had discussed regarding two DMT interventions I had found to be helpful in increasing and/or maintaining PMA. I shared how PMA is important in DMT, which aided further discussion in finding similarities between our approaches to facilitating PMA. In this meeting, we began to brainstorm ways that DMT might be integrated with the use of therapy dogs to promote PMA, which helped establish the focus of our third meeting together.

**Meeting 3.** After transcribing the two recordings of the second meetings, I highlighted sections where I found potential for the development of PMA interventions and the two transcripts were compared for similarities and differences related to the consultant's approaches, thoughts on PMA, and how PMA is utilized in their groups. The transcripts aided in informing the discussion of the interventions for the third round of individual meetings held with the consultants. Due to scheduling conflicts and time constraints, I was unable to meet with Consultant A in-person, so a phone call was scheduled after meeting with Consultant B.

Before meeting with Consultant B, I concretized and typed three DMT interventions that I found helpful in my past experiences with adults diagnosed with psychotic disorders that relate to PMA. I described each intervention to her in detail. After each description, we discussed ideas of how the therapy dogs could be incorporated. This meeting concluded with a draft of three DMT interventions incorporating therapy dogs with the goal of increasing and/or maintaining present moment awareness.

Due to time and schedule conflicts, Consultant A was phoned, and I shared the intervention ideas that Consultant B and I had discussed. This information was well-received, and she provided a few additional edits and ideas that could be incorporated into these

interventions. These edits were shared with Consultant B in the next meeting. Since this meeting was executed over the phone, notes were typed to the best of my ability.

**Meeting 4.** For this meeting, individual phone calls were held due to scheduling conflicts prohibiting in-person meetings. During these individual phone calls, specific details related to the pre-implementation trial were discussed. These phone calls allowed us to identify and develop the language needed to facilitate the interventions, and further clarify the roles of the dance/movement therapist, dog handlers, volunteer dog handler, and the animals. We reviewed the interventions and their intentions, discussed potential implementation issues, and made any necessary revisions to the interventions or their facilitation.

**Implementation trial.** I facilitated an implementation trial of the interventions with five DMT peers, the therapy dog handlers, and the therapy dogs. The goal was to receive constructive feedback regarding the effectiveness of the interventions. The setting for this implementation trial was held in the music therapy room at Consultant A's place of work. Chairs were set up in a circle for each participant and the therapy dog handler to be seated for introductions and the first half of the trial. Chairs were shifted according to the needs of the interventions being facilitated. I documented this feedback with an audio-visual recorder that was placed on a tri-pod. This tri-pod was placed on the periphery of the room to allow for maximum area to be captured. This information was stored on my computer under a password protected file to ensure safety of the data.

Participants entered the room alongside the therapy dog handlers and the three therapy dogs. Once everyone was settled in the room and seated in chairs in a circle, I went over the plan for the day. Peers were informed that they would be embarking on an at least a four-hour time

commitment for the implementation trial (See Appendix E). This was reiterated upon arrival to the implementation trial, along with an explanation for the layout of the day.

The participants were given the directive to maintain their awareness of themselves as individuals who have some knowledge and/or experience with the population, setting, and/or goals rather than role playing adults with psychosis. When providing feedback, participants were asked to consider their feedback from that position of knowledge about the population, and their authentic present moment experiences in the trial. They were informed that these interventions were designed for adults diagnosed with psychotic disorders, and were to keep in mind that this implementation trial would take place in an adult in-patient and/or outpatient psychiatric treatment facility. Participants were informed ahead of time that the overarching goal of these interventions is to increase and/or maintain present moment awareness in adults diagnosed with psychotic disorders.

Following this description, an explanation of the plan for the day was given. Participants were informed that they would participate in three 30 minute simulated interventions, not full therapy sessions. A small, open discussion among peers, myself, and the therapy dog handlers of expectations for the implementation trial was given. First, we covered any rules for safety and safety expectations that may be addressed if this were a real therapy session. Then, we went into further detail regarding the agenda for the day. Each intervention was scheduled for thirty minutes with a five-minute break afterwards, followed by thirty minutes of processing and feedback. Participants provided information regarding what seemed to work well in the intervention, how I as the facilitator held the space, any changes or shifts that could be made to the interventions for the future, how the work with the therapy dogs aligns with DMT, and how a DMT application could be further integrated.

Once feedback and processing of the first intervention was complete, peers, therapy dogs, and their handlers were given a ten-minute break for recuperation. The second and third interventions proceeded in the same manner described above and a ten minute break was offered between interventions two and three. At the conclusion of the implementation trial, peers, therapy dog handlers, and therapy dogs were offered space to practice self-care in response to anything activating that arose in group. As neither peers nor therapy dog handlers expressed a need for this space, all participants were thanked for their time and we exited the space together.

### **Ethical Considerations**

Prior to utilizing the Delphi method, collaborators received an agreement form to ensure their identity. This agreement form stated they would remain anonymous and clarified their roles for this thesis project. All interview transcriptions, agreement forms, and data were stored on my personal computer under a password protected file. A conversation of bias utilizing the Delphi method was held with each collaborator. From the beginning of the interviews, it was clear that all three of us believed in the importance of PMA in clients to optimize effective treatment. In addition to ensuring a smooth, collaborative process, conversations regarding the roles and expectations of the therapy dog handlers during the meetings and the implementation trial occurred. As consultants, the interventions developed were not claimed by them. Furthermore, the five DMT peers were given an agreement form explaining their roles and expectations for the implementation trial. Prior to beginning the trail, these roles were re-evaluated and discussed to ensure a clear understanding for the outline of the trial. The five DMT peers' identities were kept anonymous and all information and agreement forms were stored under a password protected file under my personal computer.

Bias occurred from our own personal experiences of working with adults diagnosed with psychotic disorders. Through conversation with the consultants, the passion and drive for our work was clear so a conversation regarding our passions was addressed and taken into account when developing the interventions. Through my experience interning, volunteering, and working at various settings that have adults diagnosed with psychosis, their cases were kept in mind when developing the interventions. The consultants agreed the interventions needed to pertain to this population's wants and needs of increasing PMA. The meetings with my consultants helped me understand the use of therapy dogs and what they are capable of in a treatment setting, which influenced my ideas of what became of the interventions.

A related personal bias for the final intervention development was my preferred approach to DMT interventions as an emerging dance/movement therapist. As a facilitator, I find PMA to be one of the most important factors when leading clients through their treatment process, including approaching the therapeutic relationship with warmth, compassion, and empathy, which all went into account for the interventions developed. As I grow into a dance/movement therapist, I recognize that my own style may shift and what I find important now in a DMT setting may differ from the future. Understanding the various cultural backgrounds of clients is also something to consider when facilitating these interventions because needs as well as, verbal and nonverbal communication styles may need to be shifted in order to have optimal healing process.

## **Chapter Four: Interventions**

The following three therapy interventions are intended for use in an inpatient or outpatient treatment setting for adults diagnosed with psychotic disorders. The size of the group room needs to be large enough so that clients and therapy dogs have ample room to freely move around, like a large day room approximately 13' x 30'. Group size should not exceed 8 clients and 4-8 therapy dogs. The purpose of these interventions is to increase and/or maintain present moment awareness in adults diagnosed with psychotic disorders through the use of therapy dogs in a dance/movement therapy session. The therapy group size depends on the ratio of how many therapy dogs to clients there are available. The amount of group participants may vary in size, though the recommended ratio of therapy dogs to group participants would ideally be no more than one therapy dog and one handler for every two clients to make up a team. This helps to ensure safety, helps the therapist to track group members, and helps group members establish a client-therapy animal relationship. A staff member at the facility may be utilized to aid the therapist in assessing who would be best suited for the therapy group prior to therapy dogs entering the facility. Clients who are experiencing intense anxiety, fear, or any other possible emotions the dog may be evoking within them should not attend this group. In addition, clients who are unable to appropriately interact with the therapy dog are not best suited for this group.

These interventions are designed to be led by credentialed dance/movement therapists practicing within their counseling approach. These interventions are to be introduced developmentally, based upon the client-therapy animal relationship established between the group member and the therapy dog, as well as the therapeutic relationship between group member and the facilitator. The first intervention may be utilized as an introductory intervention,

while the other two interventions are to be utilized later in the treatment plan after trust, safety, bonding, and a therapeutic relationship have been established.

### **Intervention One: Getting to Know You**

This first intervention begins with the therapy dogs and their handlers already present in the room. Clients are informed prior to the beginning of group that this is a dance/movement therapy group utilizing therapy dogs. Clients are invited into the room with chairs positioned in a circle, so that handlers and clients may be seated comfortably during introductions. To set up this first intervention, therapy dog handlers introduce their therapy dogs and share history about the dogs such as how the handlers adopted or received their dog, the dog's likes and dislikes, and some personality traits of the dog. The therapist also reviews guidelines for safety of the clients and the therapy dogs such as informing clients on how much pressure they can apply to the dog, areas of the dog that are appropriate for touch, and ways of stroking the dog to maintain safety for all involved.

Once introductions are made for the setup of this intervention, clients are instructed to divide into teams. These teams consist of one therapy dog, one therapy dog handler, and one client. Depending on how many clients are in the room and how many therapy dogs are available, a ratio of two clients to one therapy dog may be necessary. The dance/movement therapist invites clients to look at their therapy dog. As they look at their therapy dog, they are cued to notice their breath. The therapist cues the clients to notice if their breathing is shallow, deep, stagnant in their chest, or *three-dimensional* (see Appendix A) and flowing throughout their body. The therapist cues them to deepen their breathing. The goal of this is to decrease any anxiety that may be occurring within the clients, and to increase orientation to the present moment by bringing awareness to their breath. Once clients have attended to breath, the therapist

guides clients to look at their therapy dog. The therapist asks them to notice the coloring, size, movements, shape, and any features of the dog that may stand out to them. The goal is to increase sensory awareness, which in turn may increase PMA.

Once clients have had a few minutes to observe their dog, the therapist asks them to touch the therapy dog with *decreasing pressure* (see Appendix A). Decreasing pressure encourages safety of the dog, because it cues clients to be gentle as to not startle or injure the animal. As the clients pet the dogs with decreasing pressure, they are asked to notice how the fur feels on their palm. The therapist guides the clients in sensory questions regarding the texture, color, and length of the fur; whether the hair follicles are coarse or delicate; and the warmth of the dog's body.

Once clients have had a few minutes to indulge in this experience of sensory stimulation, the dance/movement therapist asks the clients to begin making small changes to their use of *Effort qualities* (see Appendix A) and the way they are petting the dog. If clients are petting the dog somewhat rapidly, asking them to decelerate their pace may be cued, or if the therapist observes the clients are petting the dog with too much *increasing pressure* (see Appendix A), the therapist may ask them to decrease the amount of pressure applied to the dog. Once clients are have shifted their use of Effort qualities, the therapist may ask the clients to return to noticing their breathing while they are stroking the dog. The therapist asks the clients if they notice any tension or places of holding in their body, and clients are then asked to breathe into those places.

The therapist then begins inviting the clients to notice their *spacing* and *shaping* (see Appendix A) towards the therapy dog. Clients are cued to notice how close in proximity they are sitting or standing to the therapy dog, how far they are reaching to pet the therapy dog, as well as their body position: are they facing the dog, side to side with the dog, or slightly turned away

from the dog. The therapist asks clients to shift the way their body is in proximity towards the dog. For those who are facing the dog, asking them to shift to the side of the dog, and for those who are side to side with the dog, asking them to face the therapy dog. The therapist cues them to notice how comfortable or uncomfortable this feels as another question guiding them into the here and now. The therapist guides the clients back to noticing any shifts within their breath, and again if there is any releasing of tension or holding of tension in the body. Then, the therapist guides the clients through noticing the shaping of their body through the use of still forms: Is it like a ball, wall, pin, or screw? These questions may aid the therapist in understanding how the client feels towards their therapy dog. For example, if the client is in a tight pin shape, they may be experiencing some discomfort, or if the client is open like a wall, they may feel comfortable with the therapy dog. The therapist is mindful of their *body knowledge/body prejudice* (see Appendix A) and will ask clients clarifying questions to ensure their initial observations align with what the client is experiencing.

Finally, the dance/movement therapist asks the clients to place a hand on the dogs' backs or stomachs, whatever is most accessible for the position the dogs are in at the moment. Clients are to *attune* (see Appendix A) to the dog's breath. The therapist asks the clients to mirror their therapy dog's breathing pattern and to notice how this breathing feels within their own body. The therapist asks questions regarding the speed of the dogs breathing: Do you notice your own breath accelerating? Does this breathing feel shallower or deeper than your own? Clients are asked to return to their own breath pattern and to notice the differences in their breath versus the dog's breath. Finally, clients are invited to notice any releasing or holding of tension within their body.

## **Intervention Two: Rhythm and Dogs**

This intervention is to be completed after clients and therapy dogs have been acclimated and have had at least three sessions together because establishing a client-therapy animal relationship is desired. This intervention begins with the clients, therapy dogs, therapy dog handlers, and dance/movement therapist seated on the floor if everyone is able. For those unable to sit on the floor, accommodations such as offering chairs or cushions should be made. The dance/movement therapist instructs clients to place one hand over their chest and one hand over their abdomen. Clients are instructed to notice their breath without changing it. The dance/movement therapist then instructs the clients to find their own heartbeat, either through placing their hand on their chest or moving one hand up towards their throat to find their pulse with two fingers.

Once clients have been given time to find this, they are to begin externalizing their heartbeat by lightly tapping their hand on the floor to the rhythm of the heartbeat. Clients are instructed to notice all of the other heart beats in the room and to notice how theirs does or does not match with the other heartbeat rhythms. Then, the therapist gradually brings this to a close and instructs the clients to command their therapy dog to lay down either beside them or in front of them, a skill gained by group members in previous sessions. Clients are instructed to place one hand gently on the dog's stomach or rib cage area to find the therapy dog's heartbeat. Once clients have had time to attune and breathe with their therapy dog, they are invited to externalize the dog's heartbeat pattern by either tapping the floor or tapping an area on their own body to the rhythm.

Then, clients are invited to look around the group to notice all of the other tapping rhythms that are occurring in the room, externalizing their dog's heartbeats. After taking time to

notice and listen to the beats, clients are invited to attune to one another by creating a group rhythmic activity together. This rhythm may be further expanded by moving the rhythm to different body parts and around the room. For example, clients may be tapping their therapy dog's rhythm on their legs which may then move up into tapping the arms. This rhythm may be taken to a standing position where clients may begin lightly marching in place, which could then take them around the room with their therapy dog. Clients are instructed by the dance/movement therapist to continue their synchronous beat while walking around the room with their therapy dog. Once the clients and their therapy dogs have a few minutes walking around the room to the heartbeat pattern, the therapist slows this walking rhythm to a pause and invites clients to return to their own breath and heartbeat by placing one hand on their chest and one hand on their stomach with their therapy dog standing or sitting by their side for support.

Finally, the therapist invites the clients to share a small movement, posture, or gesture that symbolizes the overall feeling gained from this intervention. If the clients experience a positive feeling from this intervention, the movement symbolizes or reflects this positive emotion. The therapist encourages the clients to recall this movement later in their treatment process to maintain feelings of positivity. If the clients share a movement that reflected a negative experience, the therapist process this with them in order to discover the feelings and emotions that surround their symbolic movement. This supports increasing PMA through their increased awareness of their feelings.

### **Intervention Three: Tricks and Training**

This intervention is completed after therapy dogs and clients have had at least five sessions interacting with one another, and after therapy dog handlers have demonstrated and allowed clients to try various tricks with the therapy dog from previous sessions. For this

intervention, clients are instructed to maintain eye contact with their therapy dog, which allows the therapist to assess present moment awareness of clients. In order for the clients to successfully have their therapy dog follow their commands, eye contact must be made between the pairing. The dance/movement therapist begins by having the clients practice maintaining eye contact with their therapy dog for at least ten seconds. While clients are maintaining eye contact, the dance/movement therapist asks the clients to do a brief body scan and to notice how maintaining this eye contact feels for them. Processing of holding eye contact may include asking the clients to notice their breath, notice any shifts within their body, or to notice any fleeting thoughts that may occur. It is important not to overstimulate the clients with too many questions, so it would be better to choose one question for this brief moment of maintaining present moment awareness.

Then, the dance/movement therapist instructs clients to find an area in the room with more space from other teams. Clients are asked to create a short agility sequence and guide their dog using three to five tricks they have learned in previous sessions with the therapy dog handler. Clients are given five to ten minutes to review and practice tricks with their therapy dog and dog handler, and then chooses how they would like to sequence them together. Clients are provided with the option of using three chairs their dog may stand, sit, or move around to enhance the experience of the agility course. The group facilitator and therapy dog handlers will reiterate the importance of safety when working with therapy dogs, and will remind group members of rules learned in previous sessions related to the use of objects in the room as a part of the agility sequence.

While clients separate into their teams with the therapy dogs and their handlers, the dance/movement therapist walks around the space and assesses any shifts within the teams. The

dance/movement therapist is to track subtle shifts within the bodies of the clients including changes in the use of effort qualities, attunement between group members and therapy dog, shaping and proximity preferences on the part of clients toward the therapy dog, and changing affect.

Once the clients have been given time to review and work through the chosen tricks, they are given at least 10 minutes to develop their agility course/movement sequence with their therapy dog. Therapy dog handlers and the dance/movement therapist provide support for the clients if they are feeling stuck or unsure in the creation of their agility sequence. Throughout the session, the dance/movement therapist maintains the therapeutic environment by observing and tracking verbal and nonverbal shifts on the part of group members. Once the clients have time to develop and practice their agility course, each team has time to show the group what they created. After all showings are complete, the dance/movement therapist verbally processes the experience with the clients. The potential for symbolism may arise during the verbal processing portion. The therapist asks the clients symbolic questions such as, “How does this agility course reflect obstacles in your life? How do you get through these obstacles? What has worked in the past when getting through a tough time? What has not worked well when you are navigating a stressful experience?”. These questions aid clients to increase awareness of their emotional experience, thus bringing them in to the present moment.

These interventions were developed with the overall goal of increasing present moment awareness in adults diagnosed with psychotic disorders through the use of therapy dogs. Intervention one completes this through establishing a relationship with the dog in order to find comfort and safety from the dog, thus enhancing clients’ overall treatment experience. Intervention two emphasizes the use of rhythm which has been proven to be an effective tool in

bringing adults with psychosis into PMA (Sandel et al., 1993). Intervention three utilizes props to externalize the client's emotions and experiences, with the support of the therapy dog, in order to navigate and discover all that is involved when completing a task which brings clients into the present moment.

## **Chapter Five: Discussion**

Although dance/movement therapy and AAT each address the use of PMA when treating adults diagnosed with psychotic disorders, the desire to take it one step further by integrating the two seemed fitting in that using the two together might facilitate a deeper level of movement, attunement, relationship, group cohesion, support, and trust. I set out to create interventions to enhance the experience of these elements of present moment awareness, and as a result, to achieve a deeper and more meaningful treatment process for clients. The purpose of these three dance/movement therapy interventions integrating therapy dogs is to increase present moment awareness in adults diagnosed with psychotic disorders. Through the use of integrating therapy dogs, clients may increase their ability to enter into the here and now by creating and establishing a relationship with their companion (Chandler, 2017). This is achieved by bringing awareness to the use of breath, effort qualities, rhythm, attunement, and sensory cues (Sandel, et. al., 1993). These interventions were developed using a version of the Delphi method which systematically organized information obtained from interviews held with the consultants (Hsu & Sandford, 2007).

### **The Dance/Movement Therapist**

Prior to facilitating these interventions, the dance/movement therapist is encouraged to obtain information of how to work with therapy dogs to identify personal areas of skill growth and expertise. By better understanding the ways in which therapy dogs are utilized, a dance/movement therapist collaborating with a therapy dog and handler is able to lead a richer session. Clients need to feel safe in knowing their facilitator has a wealth of knowledge in order to know how to work with all individuals in the room. Attention should be given to ethics and safety when using therapy dogs and their handlers in a room with adults diagnosed with

psychotic disorders. It is recommended that the dance/movement therapist has previous experience in working with this specific population in order to achieve best practice.

Understanding the population, their needs, and their capabilities is essential, so the therapist has a solid foundation before adding in the element of therapy dogs.

The dance/movement therapist is encouraged to explore and identify their DMT theoretical approach when reviewing these interventions. Although these interventions may be altered and adjusted to the needs of the clients and the style of the therapist in the therapy setting, it is important the therapist feels confident in the structure of the interventions, so they align with their natural and authentic way of working. Bringing attention and awareness to their body knowledge/body prejudice is also important when facilitating these interventions (Moore & Yamamoto, 2012). It is important to bring awareness to this because the meaning of body movements differs across individuals. The therapist needs to be warm, patient, and direct when working with adults diagnosed with psychotic disorders (Reichenberg & Seligman, 2016 ). Being open to verbal and movement processing throughout the session is encouraged. Verbal processing does not always need to occur at the end of the session, so if the therapist deems the processing is better suited mid-intervention, this is encouraged.

Being warm and direct are characteristics that are encouraged in the working relationship with the therapy dog handlers and their companions. This is to ensure that all individuals who are aiding in the facilitation of the group are clear on their roles upon entering the therapy session. The therapist needs to specify what is needed from the handlers in the session, be open to discussing client issues or concerns within the limits of confidentiality, and be open to providing feedback for the handlers and their work completed in the session, as well as receiving feedback from the handlers. Committing time and effort into developing a relationship with the handlers is

highly encouraged, so that therapy sessions for the clients run as smoothly and cohesively as possible. It is recommended that the dance/movement therapist emphasizes the importance of this if the therapy dog handlers are not familiar or do not agree with the use of PMA. Agreement on the goal of increasing PMA in adults diagnosed with psychotic disorders should be discussed with the handlers early on since so the handlers understand and are knowledgeable on the rationale for why increasing PMA is important (Shonin, Gordon, & Griffiths, 2013). If handlers are clear on the goals and reasoning, this will help them to aid clients in staying on track with the goals implemented by the therapist.

In order to ensure a conducive, cohesive relationship with the therapy dog handlers, it is important to identify and understand the various ways bias and cultural competencies may be shown. Identifying this early on in the relationship is recommended so that discussion and adjustments can be made as needed. Some differences that may occur when working with a therapy dog handler could be: generational gaps, cultural differences, personality differences, differences in therapeutic approach, differences in communication style with clients, differences in movement qualities and preferences, different ideas on incorporating the therapy dog in the session, and different experiences of work completed with adults diagnosed with psychotic disorders.

### **Intervention Rationale**

The interventions were grounded in a person-centered approach, focused on empowering clients to guide their own treatment outcome, which aligns with a solution-focused approach (Pichot & Coulter, 2007) and is supported in the literature on the treatment of psychotic disorders (Walter, & Peller, 1992). Consultant A described how this is approach reflects the work of therapy dogs in that they are non-judgmental, supportive animals that aid in empowering clients

in their work. One example shared was of a client who was working on increasing his ability to maintain concentration. She observed that when he was in a verbal therapy group, he expressed difficulty concentrating on reading and writing when worksheets were given, or was unable to maintain focusing on other group members sharing their experiences. When this man attended the therapy dog sessions, he was able to follow instructions given in the group, and command the therapy dog through various tricks majority of the session. Consultant A shared this client had difficulty maintaining concentration due to his auditory and visual hallucinations, but was able to push that aside when the dog was in the room. These skills learned from the work with the therapy dog were taken into conversations with the clients regarding their everyday life situations.

Similarly, the DMT interventions reflect a strengths-based model incorporating a person-centered, solution-focused approach. Specifically, the first intervention was created so that clients feel comfortable, supported, and empowered when they begin their relationship with their therapy animal (Chandler, 2017). Leading clients through the exploration of various effort qualities, breath, movement, and touch with the therapy dog, allows them to come to a deeper understanding of themselves and their emotions, and how others view them (Hackney, 2002). Although this intervention exploration may feel quite structured, the clients have some choices as it relates to how they interact with their therapy dog with the therapist serving as a model, which is reflected in a solution-focused approach (Walter, & Peller, 1992).

This approach is also addressed in the second intervention through the use of rhythm. One way to allow clients to feel connected, supported, and empowered is by bringing the group together through dance, rhythm, and movement to create a sense of community (Sandel et. al., 1993). Being a part of a communal, unified rhythm and actively engaging in a shared movement

with a group can provide an increased sense of self, feelings of enlivening, and a greater flow of energy throughout the self and the group (Sandel et al., 1993). Rhythm aids to organize and provide structure when internal and external disorganization happens, which is often apparent in individuals diagnosed with psychotic disorders. When clients are led through a unified rhythm, they may find success being in the present moment (Chaiklin & Wengrower, 2009). This reflects a person-centered, solution-focused approach because clients are empowered to make the choice of how the unified rhythm is created, shifted, and closed with some direction provided from the facilitator.

In the third intervention, clients are allowed to create their agility course however they wish, as long as it is deemed safe by the facilitator and therapy dog handlers. When clients lead their therapy dog through the course, they are encouraged to work through the course to find a solution that highlights their and their individual strengths as well as those of their therapy dog. It is expected that clients may face some challenges such as inability to maintain eye-contact with their therapy dog in order to successfully lead them through the course, or working through different obstacles to find tricks that work best with their course. This brings awareness to their body, posture, and gestures, which highlight a present moment experience (Chaiklin & Wengrower, 2009). The end of this intervention gives clients a chance to show other group members what they have accomplished, which allows them to feel empowered, thus reflecting a solution-focused approach (Walter, & Peller, 1992).

The interventions also reflect a person-centered approach through their emphasis on the therapeutic relationship. Therapy dogs can serve as a primary source of connection for clients (Wesley, 2007) and can aid them in forging a therapeutic relationship with the therapist as well as peer relationships. Consultant A shares with her clients that her therapy dog was found on the

street as a puppy and seemed to be homeless for some time. This aids her clients in building connection with the therapy dog, because several of them can relate to the feeling of unsafety, not belonging, or isolation. Consultant B shared that one of her therapy dogs was seized from a shed with six other Pitbulls without food and water. Due to the trauma he experienced, he has severe anxiety and experiences good days and bad days, just like a person who has anxiety. When clients hear that the therapy dog will remain on medication for the remainder of his life, they appear to become more comfortable and connected since several of them took the same medication as this dog. These case examples informed the development of Intervention One. Providing a designated time and space as well as guided intervention for the therapy dog and client to get to know one another can support clients in feeling more accepted and at ease when beginning the work with therapy dogs.

Consultant A further described this connection, stating that clients felt understood by her therapy dog and communicated with the animal in a way they could not communicate with her. She shared that when she entered the room, clients showed signs of resistance and inability to connect with one another, but when her dog sat beside them they would get down on the floor to sit with him and connect non-verbally. She stated, “The clients connected with him in a way he doesn’t sit with me...there are people who must need him in a way that he understands”. Thus, the interventions were developed with this in mind by...

Therapy dogs also provide comfort in sessions (Chandler, 2017). Consultant A described a group of men she worked with who had very limited social and communication skills. When her therapy dog was in the room, they appeared to become more comfortable in sharing their experiences with her; thus, their social and communication skills increased due to this level of comfort provided by the dog. Barak and colleagues (2001) found similar results in their AAT

sessions. When they utilized therapy dogs in their sessions for adults diagnosed with schizophrenia, clients' communication skills increased. The DMT interventions were created with consideration for this role of comfort that therapy dogs provide. This is demonstrated in intervention one through gradually inviting clients to join in a relationship with their therapy dog by spending time getting to know one another. In the second intervention, clients are encouraged to externalize their therapy dog's heartbeat. Studies support that hearing the heartbeat of someone you are in relationship with provides the same feeling of making eye-contact with the person (Janssen et al., 2010). If clients show difficulty maintaining eye-contact with their therapy dog, rhythm of the heartbeat may achieve this, thus increasing the goal of providing comfort and establishing relationship (Janssen et al., 2010). Finally, in the third intervention, clients have the therapy dog alongside them to support them in creating the agility course, and then executing the agility course which supports the idea of increasing comfort (Chandler, 2017).

Consultant A shared how such skills could be transferred outside of the treatment setting by asking questions such as, "You may have a hard time socializing with people, but you can sit and talk to the dog so easily. How can this help you move to the next step?" Clients provided examples of how having the dog with them out in their everyday lives would be helpful, but is not easily attainable due to financial restrictions, care, and responsibility that come with owning a dog, so potentially thinking of the dog or carrying a picture of a dog could provide a level of comfort when interacting with others.

Furthermore, utilizing therapy dogs in the therapy setting may aid in motivating clients to adhere to their treatment plan and continue working towards their healing process (Wesley, 2007). This is especially relevant for those with psychotic disorder given that approximately 50% of individuals hospitalized for schizophrenia will experience relapse within two years of

their first episode, mainly due to clients' inability to follow their treatment plan potentially consisting of taking their medication, maintaining therapy, and engaging with their support system (Reichenberg & Seligman, 2016). Consultant A shared how she has noticed that if a veteran is training to walk, they walk further and longer if they walk her therapy dog, because they find a sense of purpose when walking the dog. Another example is of a veteran who was training to get movement back into his hand. He was unwilling to do the hand exercises given to him, but was willing to brush the therapy dog or throw his toys to fetch, which accomplished the same movements, just in a different way.

Similarly, Consultant B shared how timing influences motivation. For example, having the expectation that a client will succeed in having the dog execute what they command the first session is unlikely, but the more the client-therapy animal relationship is built, the more attentive and responsive the dog becomes toward the client; thus, positively reinforcing the client to remain motivated to continue with the sessions. She noted that because the dog relies on the client for guidance, and offers friendly, affectionate, and non-judgmental support, it motivates clients to do better each time. This example was taken into account when developing Interventions Two and Three because allowing time for the animal to client relationship to develop seemed essential when facilitating these interventions. Chandler (2017) agrees that allowing time for a relationship to build between therapy dog and client is crucial to their treatment process. Leading the clients through rigorous and extensive interventions that involve the practice and execution of several tricks does not seem beneficial during the beginning stages of the therapy dog to client work together, so allowing time for these skills to develop highlights the client's strengths in their successes with their therapy dog (Pichot & Coulter, 2007).

Consultant B shared an example of how therapy dogs can assist clients in shifting their affect and mood. She described one client who was generally very quiet and reserved, but when paired with an exuberant, excited dog, the client demonstrated those qualities as well. Similarly, dance/movement therapists guide their clients through effort fluctuations (Moore, 2014). Often times, due to pathology presentation that coincides with psychotic disorders, patients may attempt to block external and internal stimuli, thus avoiding eye-contact, not responding to questions cued by others, and express an inability to shift out of their preferred effort qualities (Chaiklin & Wengrower, 2009). Chaiklin and Wengrower continue, “The dance/movement therapist, in an attempt to focus the patient on more appropriate, reality-oriented processes, might direct the DMT activity in sessions toward a heightening of awareness of simple, non-threatening stimuli- sensing temperature, color, tactile stimulation, texture...” (2009). This is reflected in the interventions created. Specifically, intervention one highlights tactile stimulation through touching the dog, and noticing the dog’s fur, warmth, and heartbeat. Visual stimulation is utilized by clients noticing the dog’s color and body shape, and internal stimulation is highlighted through clients noticing their breath and shifts in their breath. This awareness of emotions, behaviors, and overall experience with the dog aids clients to enter into PMA (Chaiklin & Wengrower, 2009).

Intervention two highlights the use of rhythm in heartbeats, which brings clients from internal stimulation of their own heartbeat, to external stimulation of their dogs’ heartbeat which involves sound, touch, and attunement to other group members to syncopate the rhythm. This stimulation of the senses and attunement supports the goal of increasing PMA (Sandel et al., 1993). The third intervention challenges clients to maintain eye-contact in order to have their therapy dog do the commands asked by the client, which aims to heighten awareness of simple,

non-threatening stimuli that Chaiklin and Wengrower emphasize (2009). This awareness of stimuli obtains the goal of increasing PMA.

Finally, both consultants described eye contact training with their therapy dogs as a primary means of increasing PMA with clients. In order to maintain eye contact, the clients need to be in the present moment to command the therapy dog to do their tricks. They shared examples of their therapy dogs walking away from or disconnecting from clients who were unable to maintain PMA through eye contact with their therapy dogs. Consultant B also shared how body posture is also an important consideration when maintaining eye contact with a therapy dog. She shared one example of how a client's shoulders were rolling forward, and as a result the dog believed the client was commanding him to lay down, so he did. Since therapy dogs are trained to listen to our commands verbally and nonverbally, such as speaking the command "sit" while gesturing with a fist in the hand, they become quite attuned to our bodies. Therefore, clients need to be mindful of how they display what they are asking of their therapy dog, which may then be carried over into their interactions with other individuals. This idea influenced Intervention One in which clients are invited to notice their spacing and shaping towards the therapy dog as a part of their body awareness in the here and now. Intervention Two incorporates the need for awareness of the body if clients are to successfully create rhythmic body action (Sandel et al., 1993). Finally, for the dogs to successfully complete their tricks in Intervention Three, body awareness is required by the clients in training their therapy dog to execute the commands given. The need for clients to establish relationship, connection, motivation, and awareness of the body were bridges that brought the two worlds of DMT and therapy dogs together.

## **Considerations for Implementation**

Three main considerations to keep in mind for implementing these interventions involve the facility where the sessions will be held, dog care and training, and preparations for the facilitator. There is much detail that needs to be taken into account prior to facilitating these interventions. Facilitators must ensure they follow certain rules, regulations, and guidelines that pertain to each of the three considerations in order to achieve best practice.

**Facility.** There are often facility restrictions related to working with therapy dogs. Several facilities do not allow for therapy dogs to enter, or do not allow for certain breeds to enter, like Pitbulls. Unfortunately, these interventions cannot be held just anywhere. The process of getting a site or facility to allow therapy dogs is a long one since it involves documentation that defends the benefits and challenges of therapy dogs at a site, health code regulations, and hospital policies and procedures. Many facilities do not have the budget to achieve such regulations, or if they do, supplies like props and equipment used for the interventions may be limited. In addition, many facilities require that the therapy dog handlers must have their certification cards on them upon entering the facility. Therapy Dogs International (TDI) and Pet Partners are the two leading organizations that certify therapy dogs and their handlers, and therapy dogs must be up to date on all of their trainings and certifications (Pet Partners, 2016; Therapy Dogs International [TDI], 2018). Finally, the consultants recommended that therapy dogs do not enter clients' rooms on an inpatient unit unless they have verbalized that this is okay for them, and as long as it is allowed by the facility's standards.

**Dog care and training.** It is important to keep allergies and disease spread in mind when bringing a therapy dog into the facility, so proper grooming, cleanliness, and health of the dog needs to be current. Annual veterinarian visits and vaccines are required for a therapy dog to

continue working in a facility. If a therapy dog is ill and experiencing vomiting or diarrhea for example, the dog should not enter the facility to work until they are healed to decrease the likelihood of illness and bacteria spreading.

Owning and certifying a therapy dog takes time, energy, and financial resources which is why several individuals do not have one for themselves. Handlers need to be mindful of the amount of time needed to ensure safety of the therapy dog and their clients. For example, as dogs grow older certain abilities or tolerances may change with their aging. Older dogs may not be able to execute certain commands or achieve some aspects of an agility course. As dogs age their tolerance may diminish. If they are working with a client who is highly acute and actively experiencing their psychotic symptoms, the dog may become agitated and intolerable of the client's behavior which can become unsafe. Consultant B shared that sometimes a dog can be certified and pass all tests, but may not be a good fit for the population. Some therapy dogs have a preference for age, gender, energy level, and symptomology of the clients they are working with. Therefore, therapy dogs need consistent assessment, and the handlers need to ensure they are up to date on all of their certifications and retests.

**Facilitators.** The facilitator of these interventions must be a credentialed dance/movement therapist. The therapist needs to implement a way of inviting clients to the group session. Some clients may be very frightened or triggered when a therapy dog enters the facility, so ensuring their own technique for inviting clients to group is crucial. Informing clients ahead of time that a dog or many dogs will be entering the site on the specific day and time is beneficial and necessary for maintaining their safety. This allows clients to prepare for meeting with a dog or to decline sessions that include the use of therapy dogs. In such cases, the therapist

or staff would identify other services that the client can receive in order to best meet their clinical needs.

The dance/movement therapist must also take into consideration how to approach facilitation of the interventions with clients who experience higher acuity in their symptoms or a history of trauma, as movement and their bodies might feel especially vulnerable and unsafe. In addition, every individual has different feelings surrounding animals and some may be more resistant to interacting with them due to fear, allergies, or lack of motivation. As such, it would be important to understand client's readiness and willingness for change and to engage in this type of treatment. The dance/movement therapist may need to modify the interventions or potentially come to the consideration that the client is not ready for these interventions during this time of their treatment process based on their stage of change. During the pre-contemplation stage, developing relationship is key in order for clients to make progress in their treatment. Therapy dogs may aid in the development of this relationship by bringing clients into a comfortable, supported, safe state which enhances the client-therapy animal relationship. Many therapists believe that trust and establishing relationship are instrumental for influencing a client's treatment outcome (Yalom, 2005). The foundation for establishing trust and a therapeutic relationship may begin with maintaining PMA. This is why the potential for integrating therapy dogs into DMT interventions may be one step in deepening and developing the client's experience of their treatment process.

Prior to implementing these interventions, if the therapist does not have their own therapy dogs, it is important the dance/movement therapist creates a time to meet with the therapy dog handler(s) to discuss expectations of the handlers, roles of the facilitator, safety concerns, overall outlines for the therapy session, and ensuring the facility in which the interventions take place is

informed of the therapy dog handlers and their dogs. In addition, working with other therapy dog handlers is another consideration when implementing these interventions. The therapist needs to be mindful of their schedule, needs, constraints, and style. Consultant B shared that her volunteer handlers have very distinct personalities, differing background experiences, and different ways of working with others. Careful supervision of the various handlers is necessary to ensure safety and success of everyone in the therapy room. Some handlers are not as receptive to feedback provided by the facilitator, so there is a potential for a negative relationship with the handlers.

### **Limitations**

Limitations of this project centered upon the implementation trial. It is recommended that prior to the trial, both consultants, the facilitator, and their therapy dogs do a run through of the interventions to increase everyone's familiarity with working together and identify possible challenges to resolve ahead of time. During the implementation trail, it was difficult for me to effectively record the session and act as facilitator, so having another individual execute this task and ensuring that the technology is working properly would be beneficial so the facilitator can maintain their own PMA with the group. It is also recommended that the implementation trial be broken down into separate times. For this project, we did all three interventions in one four-hour time frame, so by the time we came to the third intervention, therapy dogs, handlers, and participants became exhausted from the processing and execution of the interventions. Allowing more time for recuperation in between trials is recommended for future implementations.

### **Implications and Future Research**

This project offers a new approach to DMT through the integration of therapy dogs. My hope for this innovative project is that other researchers and clinicians could find this integrated

approach useful and expand upon the interventions developed. My intention for this project was to build upon the use of integrating therapy dogs in the therapy setting as another in-road to connection with individuals diagnosed with psychotic disorders. This project supports the benefits of incorporating therapy dogs in the therapy setting which may influence hospitals and other treatment settings to allow for therapy dogs to be on site. Expansion of these interventions can potentially be applied to other populations, not specifically just to adults diagnosed with psychotic disorders, as well as incorporate the use of different therapy animals. My hope is that this project could evolve into a program in the future. I imagine a wellness center where individuals can embark on an integrated healing process that incorporates therapy animals in DMT sessions.

Research is lacking in the combination of creative arts therapies and animal-assisted therapy generally and specifically for adults diagnosed with psychotic disorders. There is much research on treatment for this population in the realm of dance/movement therapy and counseling and AAT as distinct modalities, but not as an integrated approach. The combination of the two inform potential research questions: Do these interventions support increasing PMA in adults diagnosed with psychotic disorders? Is this integrated approach more effective than either approach individually? How might PMA increase effectiveness in other therapeutic factors? How can increased PMA enhance the therapeutic relationship? How can increased PMA enhance nonverbal communication between client and the therapy dog?

In order to expand upon the development of interventions, interviewing and consulting with more than two therapy dog handlers could be implemented for the purpose of gathering more information and case examples to benefit the dance/movement therapist in generating more interventions. Furthermore, if the dance/movement therapist desires more open discussion for

developing the interventions, holding meetings with two or more consultants as a group may be more beneficial than individual meetings.

In conclusion, this research will shape my future work, expanding on the relationship between therapy dogs and DMT. During the implementation trial, several peers were surprised at how the two worlds aligned so naturally, which validated my feelings surrounding the excitement and potential for this work. The idea of sharing my experience, this research, and this alignment of therapy dogs in a DMT setting with other dance/movement therapists, animal assistance therapists, and therapy dog handlers feels incredibly exciting for what the future holds.

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## **Appendix A**

### **Definition of Terms**

#### **Accelerating**

Categorized under the Effort element of time, accelerating is when the body moves with quickness, speed, urgency, or suddenness (Moore, 2014).

#### **Attunement**

A way of empathizing with another through movement that includes kinesthetic identifications within the muscles (Chaiklin & Wengrower, 2009).

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

Taken from The Delta Society, Pichot and Coulter (2007) provide the definition of animal-assisted brief therapy (AAT) as, "...a goal-directed intervention in which the animal meeting specific criteria is an integral part of the treatment process. AAT is delivered and/or directed by a health or human service provider working within the scope of his/her profession. AAT is designed to promote improvement in human physical, social, emotional, and/or cognitive functioning. AAT is provided in a variety of settings and may be group or individual in nature. The process is documented and evaluated" (Delta Society, 1996, p.79 as cited in Pichot and Coulter, 2007, p. 18-19).

#### **Binding Flow**

Categorized under the Effort element of flow, bound flow is when the body moves with controlled, restrained, or careful movements (Moore, 2014).

#### **Body Knowledge/Body Prejudice**

Our body knowledge is making sense of movement through connecting physical experiences with abstract concepts in order to draw upon generalizations based on our movement

experiences. Body prejudice involves the biased negative or positive associations with our body knowledge (Moore & Yamamoto, 2012).

### **Client-Therapy Animal Relationship**

Not to be confused with the human-animal bond where the owner and animal have a strong attachment to one another, but the client-therapy animal relationship is a social connection that is formed through the human-animal attachment process. “The therapy pet can facilitate the client’s exploration of interpersonal relational dynamics and move the client toward greater functionality in relationships (Chandler, 2017).

### **Dance/Movement Therapy.**

For the purpose of this project, dance/movement therapy(DMT) is defined as a therapeutic process that the therapist and client embark on together to creatively explore and express thoughts, emotions, and movements, which are expressed through the whole self - body, mind, and spirit- to achieve greater healing and enhance the client’s well-being.

### **Decelerating**

As related to the Effort element of time, decelerating is when the body moves with prolonging movements, slowing down, or graduality (Moore, 2014).

### **Decreasing Pressure**

Categorized under the weight Effort element, decreasing pressure is when an individual moves their body with lightness or delicacy (Moore, 2014).

### **Delusions**

“Delusions are fixed beliefs that are not amenable to change in light of conflicting evidence. Their content may include a variety of themes (e.g., persecutory, referential, somatic, religious, or grandiose)” (American Psychiatric Association, 2013, p. 87).

## **Effort Elements**

Developed by Rudolf Laban, Effort is the term used to describe how an individual moves their body (Moore, 2014). Effort includes four elements of space, time, weight, and flow which are the four movement qualities that an individual can move within. These Effort qualities may be used, and generally are used in combination.

## **Effort Qualities**

Effort qualities describe an individual moving within the same motion factor while fluctuating between the two differing attitudes (Moore, 2014).

## **Flow**

Flow is the Effort element that describes the body's control when moving. Its effort qualities include bound and free flow (Moore, 2014).

## **Freeing Flow**

Categorized under the Effort element of flow, free flow is when the body moves freely, fluently, or in a relaxed manner (Moore, 2014).

## **Group Cohesion**

“The result of all the forces acting on all the members such that they remain in the group, or, more simply, the attractiveness of a group for its members” (Yalom, 2005, p.55). This includes the relationship between group members, relationship between therapist and clients, and the individual's regard for the entire group itself. The importance of group cohesion is so that individuals may find the ability to share their inner world, so that it is received by other group members (Yalom, 2005).

## **Group Rhythmic Activity**

It is a shared rhythm while engaging in movement within a group with the goal of increasing awareness of oneself, such as integrating the mind, body, and spirit (Sandel et al., 1993). Group rhythmic activity enables a group bond through empathic responses within the body towards others (Sandel et al., 1993).

## **Hallucinations**

“Hallucinations are perception-like experiences that occur without an external stimulus. They are vivid and clear, with the full force and impact of normal perceptions, and not under voluntary control” (American Psychiatric Association, 2013, p. 87). The most common type of hallucinations are auditory hallucinations. “Auditory hallucinations are usually experienced as voices, whether familiar or unfamiliar, that are perceived as distinct from the individual’s own thoughts” (American Psychiatric Association, 2013, p. 87).

## **Human-Animal Bond**

This is the term used to describe the bond that occurs between a pet and their owner that involves an on-going relationship that is voluntary and benefits both sides (Tannenbaum, 1995).

## **Increasing Pressure**

Increasing pressure falls under the weight Effort element, which is described as moving the body with strength, firmness, or force (Moore, 2014).

## **Laban Movement Analysis**

“Laban Movement Analysis provides a comprehensive vocabulary and analytic framework for the description of human movement. Using LMA, one can systematically look at a unit or phrase of movement in terms of the four major movement components: Body, Effort,

Shape and Space. These basic components can be identified and examined alone and in relationship to each other” (Laban/Bartenieff Institute, 2009).

### **Present Moment Awareness**

For the purpose of this project, present moment awareness is a moment where a patient is able to tolerate their psychotic symptoms in order to orient to person, time, and space.

### **Schizophrenia Spectrum and Other Psychotic Disorders**

“Schizophrenia Spectrum and Other Psychotic Disorders include schizophrenia, other psychotic disorders, and schizotypal (personality) disorder. They are defined by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms” (American Psychiatric Association, 2013, p. 87).

### **Shape**

Shape has been redefined by movement experts as the formation the body molds into, or can be used to describe the pathway the body takes when in motion (Moore, 2014).

### **Space**

Space is the Effort element used to describe the orientation of movement. This includes the effort qualities of direct and indirect (Moore, 2014).

### **Therapy Dog**

“Therapy dogs are usually the personal pets of their handlers and work with their handlers to provide services to others. They function to enhance the lives of human beings through emotional and physical support. They differ from service dogs, which are trained to do work or perform specific physical tasks for the benefit of an individual with a disability” (Wesley, 2007, p. 26-27).

## **Therapeutic Relationship**

The therapeutic relationship is the relationship established over time between the client and therapist in the treatment setting. This relationship is essential in the therapy setting and aids in client's treatment success (Firestone, 2016).

## **Three-Dimensional Breathing**

Breath that flows throughout the entire body through the vertical, sagittal, and horizontal dimensions with the goal of releasing tension and centering the mind and body (Hackney, 2002).

## **Time**

Time is the Effort element that describes the pace the body is moving. This includes effort qualities of accelerating and decelerating (Moore, 2014).

## **Weight**

Weight is the Effort element that describes the amount of pressure used when the body is in motion. Its effort qualities include increasing pressure and decreasing pressure (Moore, 2014).

## **Appendix B**

### **Interview Questions**

How did you come to find animal-assisted therapy?

How long have you been a therapy dog handler?

Where have you worked/are currently working?

What is your counseling approach or what approaches have you seen/know about?

What is your definition of animal-assisted therapy?

What are your general group goals when holding therapy dogs in a session?

What have you found most important about integrating animals into the therapy setting?

What are strengths about having therapy dogs?

What is your approach when introducing the animal to the patients?

Are other staff informed when you bring the animal onto the unit?

How is safety of the patients, yourself, and the animal incorporated into your approach?

What shift occurs in the patients when the animal interacts with them?

For the goal of increasing present moment awareness, what have you witnessed when bringing the animal into the room?

What challenges have you witnessed with therapy dogs and this population?

How does this work look in various settings with adults diagnosed with psychotic disorders?

What challenges have you witnessed with therapy dogs and working in various settings?

What do you know about dance/movement therapy?

How do you envision therapy dogs in a DMT session?

## Appendix C

### Agreement with Consultants/Therapy Dog Handlers

I \_\_\_\_\_ agree to be a contributing role with Dani Owens for her thesis exploring the development of interventions that integrate the use of therapy dogs into dance/movement therapy. In this contributing role, I will share my experiences and knowledge of working with therapy dogs and am aware that my information given may be used in her thesis. I will not share any identifying information about clients who have been a part of therapy dog interactions. I am a therapy dog owner and handler and have worked/am currently working with psychiatric patients. I agree to meet with Dani on 10/13/2017 and five times after the initial meeting for the purpose of: educating Dani on how I utilize my therapy dog(s), discussing my experience as a therapy dog handler, and collaborating with her to aid in discovering overlaps that the use of therapy dogs and dance/movement therapy may have. I understand and give permission that my direct words may be used and referenced for this thesis and any other future publications. I understand that this is part of her requirement to fulfill her Master's Degree in Dance/Movement Therapy and Counseling. I understand that my name and identifying information will not be shared.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature (Thesis Author) \_\_\_\_\_ Date \_\_\_\_\_

## Appendix D

### Volunteer Animal Handler Agreement Form

I \_\_\_\_\_ agree to obtain the role as a volunteer animal handler for Dani Owens' pre-implementation trial on **January 28, 2018**. This trial serves the purposed of integrating therapy dogs into dance/movement therapy interventions to help adults diagnosed with psychotic disorders increase and/or maintain present moment awareness. I understand that participants will be mindful of adults diagnosed with psychotic disorders, not fully role-playing or embodying this population. As an experienced dog therapy handler, I agree to aid participants in demonstrating skills the therapy dog exhibits, aid participants in working with the therapy dog, and any other roles Dani may request of me when leading the interventions. I understand and give permission that my direct words may be used and referenced for this thesis and any other future publications. I understand that this is part of her requirement to fulfill her Master's Degree in Dance/Movement Therapy and Counseling. I understand that my name and identifying information will not be shared.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature (Thesis Author) \_\_\_\_\_ Date \_\_\_\_\_

## Appendix E

### Implementation Trial Agreement From

I \_\_\_\_\_ (sign name) \_\_\_\_\_ agree to participate in Dani Owens' implementation trial where she will facilitate three simulated interventions that she developed with two therapy dog handlers. I understand that my participation in these simulated interventions will not be for personal therapeutic purposes, but that I will be mindful of adults diagnosed with psychosis in the setting in which Dani has identified. I am informed that an audio-visual recorder will be used. I agree to meet with Dani on **Sunday, January 28, 2017** at \_\_\_\_\_ (location) \_\_\_\_\_ at **4:00 pm**. I understand that I will participate in simulated group therapy interventions for those diagnosed with a psychotic disorder alongside other colleagues, two therapy dog handlers, one volunteer dog handler who works alongside one of the consultants, and three therapy dogs. I understand that this entire trial may last up to four hours and am willing to commit to the time. I have experience in working with adults diagnosed with psychotic disorders and agree to give constructive feedback after each intervention to aid in Dani's thesis process. I understand feedback provided from these simulated interventions will be used for her thesis, and I understand that this is part of her requirement to fulfill her Master's Degree in Dance/Movement Therapy and Counseling. I will maintain my awareness of myself as an individual who has knowledge and experience with this population, setting, and goals. I agree to give feedback from that position of knowledge as well as my authentic present moment experiences. I understand that my name and identifying information will not be shared in the written thesis.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature (Thesis Author) \_\_\_\_\_