



## AN ABSTRACT OF THE DISSERTATION OF

Katy Schroeder for the degree of Doctor of Philosophy in Counseling presented on November 21, 2016.

Title: Equine-Assisted Group Work: An Exploration of Therapeutic Factors and Group Practices

Abstract approved:

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Equine-assisted group work has recently emerged in the empirical literature as a promising treatment approach for a variety of populations, including women trauma survivors (Whittlesey-Jermone, 2014; Shambo, Seely, & Vonderfecht, 2010). However, group therapeutic processes (e.g., therapeutic factors) and group leader characteristics have yet to be studied in equine-assisted groups.

This dissertation encompasses two empirical investigations. The purpose of the first investigation was to delineate group therapeutic factors present in equine-facilitated group psychotherapy (EFGP) for women survivors of interpersonal violence ( $N = 9$ ), and how these factors occurred over time. After each of the eight-week EFGP intervention groups, participants completed the Critical Incident Questionnaire (CIQ; Kivlighan & Goldfine, 1991), a qualitative assessment which prompts group members to describe their most important session events. Data were examined using a qualitative content analysis approach. Instillation of hope, self-understanding, learning from interpersonal action, and guidance were the most frequently

observed factors in the EFGP group sessions. These therapeutic factors were also found across group session activities, and during group member-to-equine interactions and member-to-member interactions. This study provides a meaningful contribution to the scholarly literature regarding therapeutic processes present during equine-assisted mental health interventions and implications for delivering equine-assisted groups for women trauma survivors.

The second study entailed a cross-sectional survey designed to explore equine-assisted mental health (EAMH) practitioners' group work education and leadership backgrounds, as well as information about the types of equine-assisted groups they provide. Further, we assessed associations between practitioners' group work education, training, and leadership experiences, and their perceived group leader self-efficacy as measured by the Group Leader Self-Efficacy Instrument (GLSI; Page, Pietrzak, & Lewis, 2001).

A convenience sample of 24 equine-assisted mental health practitioners completed the survey. Respondents' reported leading multiple types of therapy groups and working with a variety of client populations. The most common presenting concerns treated with equine-assisted group work were depression, anxiety, or trauma. Chi-square analysis was conducted to assess associations between EAMH practitioners' group work education, training, and leadership experiences. Results indicated a statistically significant association ( $p = 0.001$ ;  $V = 0.67$ ) as participants with more education, training, and experience evidenced higher group leader self-efficacy scores than those who had less.

It appears that knowledge of group therapeutic factors can aid EAMH practitioners in facilitating group interactive processes, and EAMH practitioners could potentially benefit from more focused group work education and training opportunities.

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Equine-Assisted Group Work: An Exploration of Therapeutic Factors and Group Practices

by

Katy Schroeder

A DISSERTATION

submitted to

Oregon State University

in partial fulfillment of  
the requirements for the  
degree of

Doctor of Philosophy

Presented November 21, 2016

Commencement June 2017

Doctor of Philosophy dissertation of Katy Schroeder presented on November 21, 2016

APPROVED:

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Dean of the Graduate School

I understand that my dissertation will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my dissertation to any reader upon request.

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Katy Schroeder, Author

## ACKNOWLEDGEMENTS

This dissertation project represents the culmination of a career journey I started ten years ago and came to fruition with the guidance and support of many important human beings (and animals) along the way. First, I would like to express immense thanks and gratitude to my family and friends; my wonderful colleagues in the equine-assisted therapy community; and my classmates in the “cutest cohort,” 64. Whether it was encouragement, advice, a shoulder to lean on, or support through meals, comfort, and laughter, I could not have made it to this moment without all of you.

I am also thankful for the support of my dissertation committee. Dr. Deborah Rubel sparked my enthusiasm for qualitative research and writing excellence. Your warm interest, teaching approach, and thoughtful feedback have been invaluable to me. Dr. Amy Ford provided tons of positivity and encouragement. I am especially grateful for your steady voice of reassurance when I felt overwhelmed by this process. Dr. Phyllis Erdman—a long-time mentor—lent her support, guidance, and expertise in numerous capacities. I am so thankful for the role you have played in my professional development.

My Major Advisor, Dr. Daniel Stroud, started this journey with me during my master’s studies, and ignited my passions for research and teaching. Your strong advocacy for my research interests; mentorship, good humor, patience, and kindness during my more anxious moments; and most importantly, your unwavering belief in my ability to reach this goal, has left an indelible mark on my personal and professional growth. Thank you.

I would also like to express my thanks to the survey reviewers who enthusiastically lent their time and feedback to the development of the survey for this dissertation, as well as my

gratitude to all the research participants, including my deepest appreciation for the women who shared their voices, experiences, and courage.

Lastly, to my little brother, Joe, who passed away near the completion of this dissertation project; I hold you so close to my heart. The ideals of peace, justice, and care for others that you so passionately embodied throughout your life will always light my way.

## CONTRIBUTION OF AUTHORS

Dr. Daniel Stroud served as dissertation chair providing oversight of manuscript development, including guidance with research methodology and design, assistance with data analysis, and manuscript editing.

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## Chapter 1

### Thematic Introduction

Group therapy has long been considered a powerful and transformative mental health treatment approach (Delucia-Waack, Kalodner, & Riva, 2014; Scheidlinger, 2000), and its various applications have expanded well beyond outpatient clinical facilities to other human services settings, such as schools, hospitals, and community-based organizations (Scheidlinger, 2000, p. 331). Scheidlinger (2000) noted that the evolution of group work practice has led to much innovation and eclecticism. Individuals now have access to a wide variety of specialized group experiences, ranging from music therapy groups (Waldon, 2001) and adventure-based therapy groups (Tucker, Norton, Itin, Hobson, & Alvalrez, 2016) to art-based (Schechtman & Perl-dekel, 2000) and body movement groups (Priebe et al., 2016). This doctoral dissertation explores two important aspects of group work within the context of an emerging area of clinical practice, equine-facilitated psychotherapy; therapeutic mechanisms of change and group leadership.

### **Therapeutic Factors in Group Work**

Group work theory and practice are firmly grounded in fundamental assumptions about human social behavior; primarily that we have an inherent drive to connect and affiliate with other human beings (Day, 2014), and that interpersonal interactions, across the lifespan, form the basis of our views of self and others (Kline, 2003; Yalom & Leszcz, 2005). Yalom and Leszcz (2005) theorized that the presence of others constitutes the primary source of change for group therapy participants (Holmes & Kivlighan, 2000); group therapy provides clients with “more people to learn from, identify with, disclose to, and with whom to form significant therapeutic relationships” (Holmes & Kivlighan, 2000, p. 483). The power of group work to facilitate client

change is believed to stem from the synergistic effect of therapeutic factors—those actions of the group leader, other group members, or the individual, which contribute to a person's psychological improvement (Bloch & Crouch, 1985).

Corsini and Rosenberg's (1955) foundational research on elements that contribute to successful group work environments paved the way for our current understanding of therapeutic factors. What emerged from their review of 300 articles were 10 therapeutic mechanisms of change: acceptance, altruism, universalization, intellectualization, reality testing, transference, interaction, spectator therapy, ventilation, and miscellaneous (as cited by Crouch, Bloch, & Wanlass, 1994). Years later, Yalom's (1968) research placed special emphasis on the importance of interpersonal learning (as cited by Crouch et al., 1994), and his classification system of group therapeutic factors continues to be the most prominent framework used to conceptualize how change occurs in groups (Kivlighan & Kivlighan, 2014). He defined these factors as: instillation of hope, universality, imparting information, and altruism; and the corrective recapitulation of the primary family group, socializing techniques, imitative behavior, interpersonal learning (input and output), cohesiveness, catharsis, and existential factors (Yalom & Leszcz, 2005). Others have put forward classification systems they believed to be less influenced by any one theory in particular. Bloch and Crouch's (1985) taxonomy consisted of the following factors: acceptance, altruism, catharsis, guidance, and instillation of hope; and learning from interpersonal action, self-disclosure, self-understanding, universality, and vicarious learning.

Decades of empirical studies have increased our awareness of the ways in which therapeutic factors operate in group work, and these investigations have been squarely positioned within clients' experiences as group participants (Kivlighan, Miles, Paquin, 2011). Early studies

asked clients to identify and rank the importance of group therapeutic factors. A review of these studies (Crouch, et al., 1994) suggested potential differences between inpatient and outpatient groups. Crouch et al.'s (1994) findings indicated outpatients placed more importance on the factors of self-understanding, learning from interpersonal action, self-disclosure, and catharsis, while inpatients most valued cohesion, altruism, universality, and instillation of hope (as cited by Kivlighan & Holmes, 2004). Ultimately, these types of rank ordering studies resulted in conflicting findings, as clients' beliefs about the importance of certain therapeutic factors varied across populations and clinical settings with no consistent pattern, or theoretical basis, to understand and account for differences (Kivlighan & Holmes, 2004).

In an attempt to better understand which therapeutic factors emerge in different types of groups, Kivlighan & Holmes (2004) conducted a cluster analysis of 39 therapeutic factors studies. Based upon therapeutic factor rankings, they were able to categorize findings from these studies into four group typologies: affective insight, affective support, cognitive insight, and cognitive support. Kivlighan and Holmes's study brought the field closer to an organizing framework for understanding which therapeutic factors are active in specific types of groups (Kivlighan & Kivlighan, 2014). Subsequent studies have provided confirmatory evidence for this typology system (Kivlighan & Kivlighan, 2014).

For instance, Waldo, Kerne, and Van Horn Kerne's (2007) study on therapeutic factors ratings in men's domestic violence groups (counseling and guidance sessions) demonstrated a strong correlation (.86) between therapeutic factor rankings in the guidance sessions and therapeutic factor rankings in cognitive support groups (as cited by Kivlighan & Kivlighan, 2014). Research in this area continues, with more recent studies directing attention to the relationship between therapeutic factors, client outcomes, (Joyce, MacNair-Semands, Tasca,

Ogrodinczuk, 2011) and group climate (Gold, Kivlighan, & Patton, 2013). As our knowledge of group work processes related to therapeutic factors have increased, so too has our understanding of how to educate and train group leaders.

### **Group Leadership**

Group leadership encompasses a specialized skill set; leaders must be able to provide an overall structure for the group process, facilitate member-to-member interactions, model appropriate behaviors, and monitor patterns of interactions to either promote open communication among members or block unproductive dialogue (Gladding, 1994). Furthermore, Tasca et al. (2014) noted that the multiple possibilities for “interpersonal interactions among participants and the functioning of the group as a whole exponentially increase the possible transactions, meanings, and interventions that could occur” (p. 28). These processes require group leaders to demonstrate flexible thinking, effectively regulate their own emotional experiences (Champe, Okech, & Rubel, 2013; Kline, 2003), and have confidence in their ability to successfully execute group leadership skills (Page, Pietrzak, & Lewis, 2001).

### **Group Leader Self-Efficacy**

Education, training, supervision, and practical experiences play important roles in group leader performance, including bolstering positive self-efficacy beliefs (Midgett, Hausheer, & Dumas, 2016; Ohrt, Robison, & Hagedorn, 2013; Springer, 2016; Wilson & Newmeyer, 2008). Albert Bandura’s (1977) social learning theory conceptualizes self-efficacy as “a task-specific belief that regulates choice, effort, and persistence in the face of obstacles and in concert with the emotional state of the individual” (Bray-Clark and Bates, 2003, p. 14). Perceived self-efficacy intersects with job performance in a number of ways. For instance, self-efficacy beliefs can impact transfer-of-learning from training settings to the workplace (Merriam and Leahy, 2005),

influence how individuals approach increasingly complex tasks (Stajkovic & Luthans, 1998), and effect how people respond to work-related stressors and challenges (Bray-Clarke & Bates, 2003). Given the complexities associated with leading therapy groups, Page, Pietrazak, and Lewis Page (2001) initiated research on how self-efficacy might influence individuals' confidence in using group leadership skills.

Page and colleagues (2001) defined group leader self-efficacy as a group leader's beliefs in his or her ability to effectively perform group leadership skills. Through a series of factor analyses, Page and colleagues developed a self-report measure, the Group Leaders Self-Efficacy Instrument (GLSI; Page et al., 2001), to begin assessing the construct of self-efficacy as it applied to group leadership. Subsequent research studies using this measure found associations between higher GLSI scores and experiential training groups (Orht et al., 2013), service learning experiences (Midgett et al., 2016), supervision support (Springer, 2016), and supplemental training resources (Zordan et al., 2015). Taken as a whole, these studies indicate that self-efficacy beliefs could play an important role in how group leaders develop and apply group leadership skills.

### **Humans and Animals in Therapeutic Relationships**

Sociologist Bryan Clifton once said: "There is virtually no area of social life untouched by animals" (Clifton, 1979, p. 403). Indeed, our various relationships with animals, whether for work, sport, leisure, or companionship, cannot be understated. Though animals have served many roles in the lives of human beings, the idea that social support from animals can alleviate psychological distress in humans is a much more recent topic of scientific inquiry. American child psychiatrist, Boris Levinson (1972), considered to be the founder of "pet-facilitated therapy" (Serpell, 2015, p.16), was one of the first clinicians to report on the benefits of

including an animal in the therapy process. Levinson (1972) noted that psychotherapy clients—both children and adults—could benefit from physical contact, acceptance, and companionship from animals, and that such experiences could even facilitate the reestablishment of relationships with other human beings. Numerous studies now exist demonstrating the psychosocial benefits of blending animal-assisted interventions with psychotherapy (Van Fleet, Fine, O’Callaghan, Mackintosh, & Gimeno, 2015).

### **Equine-Facilitated Mental Health Services**

Though standardized terminology remains elusive (Latella & Abrams, 2015), equine assisted mental health (EAMH) treatment is commonly referred to as Equine-Facilitated Psychotherapy (EFP), Equine-Assisted Psychotherapy (EAP), or Equine-Assisted Counseling (EAC), and is a sub-specialty within the broader field of equine-assisted activities and therapies (EAA/T) (Hallberg, 2008). These approaches generally involve the integration of specific psychotherapy or counseling techniques with equine-assisted activities, and are facilitated by a licensed or credentialed mental health provider, in order to address the therapeutic goals of individual clients and groups (Hallberg, 2008). The equine-assisted activities typically used in treatment include horsemanship practices, such as grooming and care activities (e.g., brushing the horse’s coat, cleaning hooves, etc.); ground-based activities, such as handling and leading a horse; and horseback riding (Latella & Abrams, 2015). How these activities are chosen, structured, and processed depends upon a client’s goals and treatment plan, as well as the mental health clinician’s theoretical orientation and preferred use of clinical techniques (Latella & Abrams, 2015).

Equine-assisted mental health (EAMH) services provide a host of therapeutic elements not otherwise available in typical clinical settings; clients are simultaneously exposed to nature,

physical activity, hands-on learning experiences, and social interaction (Hallberg, 2008).

Research on the theoretical underpinnings of EAMH interventions is still in its infancy (Bachi, 2012); however, several propositions have been put forward. Some draw on well-known theories of personality. For instance, Bachi (2013) suggested that from an attachment theory perspective, clients' ways of interacting with, and relating to, a therapy horse can reveal their primary attachment style, aiding the clinician in the assessment process. Furthermore, as a non-verbal and nonjudgmental member of the treatment team, horses can support therapists in providing a safe therapeutic holding environment for clients to grow and change (Bachi, 2013). The concepts of a secure base and holding environment are extended in this environment, as clients are able to gain comfort from connecting physically with horses (Bachi, 2013).

Others contend that the Biophilia hypothesis (Kellert & Wilson, 1993), or human beings' natural proclivity to connect with nature (and, by association, animals) is another useful way to conceptualize the healing potential of equine-assisted activities (Hallberg, 2008). Several books on the subject hone in on equine-specific characteristics, such as their sensitivity to others' emotions, willingness to socialize and cooperate, and their powerful stature, as some of the driving forces behind therapeutic experiences for clients (Hallberg, 2008; Parish-Plass, 2013; Trotter, 2012).

A number of populations have reportedly benefited from EAMH interventions, including youth at-risk (Trotter, Chandler, Goodwin-Bond, & Casey, 2007), adolescents with substance use disorders (Kern-Godal, Arnevik, Walderhaug, & Ravndal, 2015), veterans (Redman, 2013), and adults experiencing serious mental illnesses (Nurenberg et al., 2015). Although the amount of outcome research on EAMH interventions is small, preliminary evidence is encouraging. For example, in one of the few randomized controlled trials on equine-assisted interventions,

Nurenberg et al. (2015) found a relationship between an equine-assisted psychotherapy group intervention and reductions in aggressive behaviors in psychiatric inpatients. Other researchers have found equine-assisted psychotherapy programs influenced adolescents' self-image and self-control behaviors (Bachi, Terkel, & Teichman, 2012), and decreased symptoms of depression and anxiety for both youth (Kemp, Signal, Botros, Taylor & Prentice, 2014) and adult (Earles, Vernon, & Yetz, 2015) trauma survivors.

**Equine-assisted group work.** A facet of EAMH service delivery with even less research support is group work. Equine-assisted group work involves the participation of horses in group therapy processes. Empirical studies reporting on the effects of equine-assisted interventions delivered in group formats primarily address individual outcomes without assessing how group interactive components impact the process. Furthermore, there is a lack information regarding the horse's influence on aspects of the group work environment, such as group dynamics, stages of development, or group climate. Thus, the field could benefit from further exploration of the interplay between the group work and equine-assisted activities. Specifically, research is needed to better understand which therapeutic mechanisms of change are present during various types of equine-assisted groups. One well-established way to investigate group interactive processes is through the exploration of therapeutic factors.

**Group leadership in EAMH settings.** The second area in need of further research is related to group leadership. Virtually no studies exist exploring characteristics of group work practitioners in EAMH settings, how group leadership education and training experiences transfer to equine-assisted groups, or how practitioners feel about their ability to apply core group leadership skills in these types of groups. Previous group leadership studies have indicated leaders desire more education and training related to their sub-specialties of practice,

such as when working with sexual abuse survivors (Gerrity & Matthews, 2006) or individuals with chronic illnesses (Zordan et al., 2010), and researchers are only just beginning to explore group leaders' confidence levels for applying core group leadership skills in specialized groups, such as cancer support groups (Zordan, et al., 2015) and school counseling groups (Springer, 2016). EAMH practitioners face unique leadership challenges when facilitating safe and therapeutically valuable interactions among groups of horses and humans. Thus, it seems imperative to gauge how practitioners feel about leading groups in this setting.

Furthermore, there are no widely accepted industry standards for training EAMH practitioners to facilitate groups with equine assistance (Hallberg, 2008). Much like the broader field of animal-assisted activities and therapies (Fine, Tedeschi, & Elvove, 2015), the professionalization of EAMH interventions requires more formalized education and training programs to ensure standards for the competent and ethical delivery of services.

### **Summary**

Group work has a long history of effectiveness, and successful groups are facilitated by skilled group leaders (Delucia-Waack, Kalodner, & Riva, 2014; Kline, 2003; McRoberts, Burlingame, & Hoag, 1998; Yalom & Leszcz, 2005). The emergence of equine-facilitated group work in the empirical literature indicates a need to explore how, and to what extent, it is currently utilized in equine-assisted mental health settings. Along these lines, it is also important to gain a better understanding of equine-assisted practitioners' education and training needs for this specialty area of group work practice. One of the most important functions of group leadership entails activation of group therapeutic factors (Kline, 2003; Yalom & Leszcz, 2005). This highlights the importance of researching which therapeutic factors might be present for members participating in equine-facilitated group work.

The first manuscript in this dissertation is part of a larger mixed methods investigation examining equine-facilitated group work for women trauma survivors. The second manuscript took shape as a result of the author's experiences as an equine-assisted group work practitioner and her desire to advocate for professional standards of practice.

### **Dissertation Overview**

In accordance with the Oregon State University Graduate School and Counseling Academic Unit guidelines, this dissertation evidences scholarly research using the manuscript-style dissertation format. This research is focused on group work practices, group leadership, and group therapeutic processes in the field of equine-assisted mental health. The two studies are designed to address specific gaps in the EAMH literature by discovering which therapeutic factors are present during group work experiences with equine-assistance, and exploring characteristics of EAMH practitioners who lead equine-assisted groups.

The first study focuses on the experience of clients who have taken part in equine-facilitated groups— specifically, women survivors of interpersonal violence. Chapter 2 of this dissertation contains a manuscript entitled “Equine-Facilitated Group Work for Women Trauma Survivors: An Exploratory Study of Therapeutic Factors,” which explores possible therapeutic factors specific to group work processes that play a role in participants' trauma recovery. The primary purpose of this study was to better understand the underlying processes of change in equine-facilitated group work approaches as a launching point for future research inquiry and to inform group work clinical practice in this specialty area of EAMH service delivery. This manuscript is intended for submission to the *Journal for Specialists in Group Work*, a peer-reviewed journal published by the Association for Specialists in Group Work (ASGW), a division of the American Counseling Association (ACA).

The second study, “Equine-Assisted Mental Health Services: An Assessment of Group Work Involving Humans and Horses,” is described in Chapter 3, and focuses primarily on the equine-assisted group practitioner. The purpose of this study was to (a) describe the group work practices of EAMH practitioners; (b) assess group leader self-efficacy of these practitioners; and (c) to explore the educational and training needs of EAMH practitioners. This manuscript will be submitted to the *Human-Animal Interaction Bulletin*, an open-access, peer reviewed journal associated with the Section on Human-Animal Interaction of the American Psychological Association’s Society of Counseling Psychology (Division 17). Finally, Chapter 4 contains a summary of the findings from both studies, along with clinical implications and future research directions.

### **Glossary of Specialized Terms**

*Acceptance* - A sense of belongingness to the group. Clients’ experiences of feeling supported, understood, and cared for by other members of the group (Bloch et al., 1979).

*Altruism* - Group member gains a boost to self-concept through extending help to other members (Bloch et al., 1979; Yalom & Leszcz, 2005).

*Catharsis* - Group members release strong feelings, whether positive or negative, about past or present experiences. This emotional release results in experiences of relief (Bloch et al., 1979).

*Cohesiveness* - Members’ experiences of closeness with the group, believed to be the overarching factor facilitating members’ feelings of acceptance, self-esteem, and wellness (Yalom & Leszcz, 2005).

*Corrective recapitulation of the family experience* - The opportunity created through group interactive processes to experience and reenact family dynamics in a corrective manner (Yalom & Leszcz, 2005).

*Development of socialization techniques* - The group provides members with an environment that fosters adaptive and effective interpersonal communication (Yalom & Leszcz, 2005).

*Existential factors* – Members’ awareness of what they can and cannot control; matters of life, separation, and death. The willingness to take personal responsibility for choices and actions (Yalom & Leszcz, 2005).

*Equine-assisted activities and therapies (EAA/T)* - An umbrella term for describing the use of equine-assisted interactions to promote individuals’ psychosocial, behavioral, and/or physical health (Latella, & Abrams, 2015).

*Equine-assisted activities (EAA)* - EAA/T program activities involving common horsemanship practices including, but not limited to, grooming and care activities (e.g., brushing the horse’s coat, cleaning hooves, etc.); ground-based activities, such as handling and leading; and horseback riding (Latella, & Abrams, 2015).

*Equine-facilitated/assisted psychotherapy (EFP/EAP)* - Interactive psychotherapy approaches involving horses, conducted by a licensed/credentialed mental health provider, in order to address the therapeutic goals of clients. Providers either have a background in working with horses, or are assisted by a qualified equine professional (Latella, & Abrams, 2015; PATH, Intl., 2016).

*Equine-assisted mental health (EAMH) settings* – Specialized clinical environments that provide equine-assisted activities in a variety of formats (e.g., groups, families, and individuals).

*Equine-assisted mental health (EAMH) services* – A general term for any type of mental health treatment involving equine-assisted, or equine-facilitated methods (Hallberg, 2008).

*Group work* - “A broad professional practice involving the application of knowledge and skill in group facilitation to assist an interdependent collection of people to reach their mutual goals which may be intrapersonal, interpersonal, or work-related. The goals of the group may include the accomplishment of tasks related to work, education, personal development, personal and interpersonal problem solving, or remediation of mental and emotional disorders” (Association for Specialists in Group Work, 2000).

*Group leader self-efficacy* - Group leaders’ beliefs in their abilities to effectively perform group leadership skills (Page, Pietrzak, & Lewis, 2001).

*Guidance* - Group members receive helpful information, such as instruction, from the group leader, or advice and suggestions from other members, in relation to problematic experiences (Bloch et al., 1979). Yalom and Leszcz (2005) also referred to this factor as Imparting Information.

*Instillation of hope* - Group member recognizing other members’ successes can be helpful, and they develop optimism for their own improvement (Bloch et al., 1979; Yalom & Leszcz, 2005).

*Interpersonal violence* - “Interpersonal violence includes acts of violence and intimidation that occur between family members, between intimate partners, or between individuals, whether or not they are known to one another, and where the violence is not specifically intended to further the aims of any group or cause. This category includes child maltreatment, youth violence, some forms of sexual violence and abuse of elders” (Rutherford, Zwi, Grove, and Butchart, 2007, p. 676).

*Qualitative content analysis* - “A research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns” (Hsieh & Shannon, 2005, p.1278).

*Self-disclosure* - Member shares personal information about self with other group members (Bloch et al., 1979).

*Self-efficacy* - Bandura (1977) first described self-efficacy as “beliefs in one’s capabilities to organize and execute the courses of action required to produce given attainments” (p. 10).

*Self-understanding* - Group member learns something important about himself or herself. This can result from feedback exchange with other members or the group leader, as well as from the leader or other members’ sharing of interpretations (Bloch et al., 1979; Yalom & Leszcz, 2005).

*Therapeutic factors* - Aspects of the group work environment that contribute to individuals’ psychological improvement as related to the actions of the group leader, other group members, or the individual (Bloch & Crouch, 1985).

*Universality* - A member recognizes that other group members share similar feelings, thoughts, and problems (Bloch et al., 1979; Yalom & Leszcz, 2005).

*Vicarious learning* - Group member personally benefits from observing other group members’ therapeutic experiences, and/or from observing the group leader’s actions (Bloch et al., 1979).

Yalom and Leszcz (2005) described this therapeutic factor as Imitative Behavior.

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## Chapter 2:

# Equine-Facilitated Group Work for Women Trauma Survivors: An Exploratory Study of Therapeutic Factors

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### Author Note

This study was made possible through support from Morris Animal Foundation (D14HA010). This manuscript has not been reviewed or endorsed by the Foundation, and the views expressed do not necessarily reflect the views of the Foundation, its officers, directors, affiliates or agents.

### Abstract

This study entails a qualitative content analysis of therapeutic factors in equine-facilitated group psychotherapy (EFGP) for women trauma survivors ( $N = 9$ ). Participants' critical incident questionnaires (CIQ; Kivlighan & Goldfine, 1991), were coded for the presence of therapeutic factors. Results indicated that instillation of hope, self-understanding, learning from interpersonal action and guidance were most frequent factors across group sessions. These and other therapeutic factors manifested in unique ways specific to the EFGP format. Implications for the practice of equine-assisted group work and directions for future research are discussed.

*Keywords:* equine-facilitated group work, therapeutic factors, interpersonal violence, qualitative content analysis

## Equine-Facilitated Group Work for Women Trauma Survivors: An Exploratory Study of Therapeutic Factors

A substantive body of research indicates violence against women continues to be a significant public health concern in the United States (Iverson et al., 2013; Jordan, Campbell, & Fallingstad, 2010). Beyond the traumatic experience(s) itself, women's exposure to interpersonal violence (IPV) has been linked with higher risk for developing post-traumatic stress disorder (PTSD), anxiety, depression, and substance use disorders (Iverson et al., 2013; Jordan et al., 2010; Rees et al., 2011). Some of the most painful and enduring effects of include diminished self-esteem, increased self-blame, and feelings of shame (Ehlers & Clark, 2000; Foa, Ehlers, Clark, Tolin, & Orsillo, 1999; Gorey, Richter, & Snider, 2001).

Furthermore, empirical literature indicates the absence of strong social ties, as well as negative post-assault reactions from abuse survivors' social networks, have been associated with poorer outcomes for women survivors of IPV (Davis, Brickman, & Baker, 1991; Ullman & Filipas, 2001). Differential treatment and stigmatizing responses (e.g., victim blaming) are particularly damaging and have been associated with greater PTSD symptom severity (Ullman & Filipas, 2001). Accordingly, social support is considered a key aspect of trauma recovery (Sippel, Pietrzak, Charney, Mayes, & Southwick, 2015; Stenius & Veysey, 2005; Ullman, 1996; Ullman, 2001), and women IPV survivors in particular have benefited from experiences of validation and emotional caring (Ullman, 1996) from medical professionals, peers, and family members (Stenius & Veysey, 2005). Group work is an effective way to reconnect women to a supportive peer network (Kelly & McGarland, 2016; McWhirter, 2006). And the unique features associated with equine-assisted activities may further enhance group treatment for women

survivors of interpersonal violence (Shambo, Seely, & Vonderfecht, 2010; Whittlesey-Jermone, 2014).

### **Group Work for Women Trauma Survivors**

The negative psychological sequelae associated with interpersonal trauma complicates treatment (Ehlers & Clark, 2000); however, group work is uniquely suited for addressing multiple domains of post-trauma recovery (Allen & Bloom, 1994; Herman, 1997). Group therapy can lessen social isolation, connect trauma survivors with a supportive peer group, provide learning experiences, as well as reparative opportunities, as part of the group process, helping individuals to heal from relational wounds (DiNunno, 2000; Ford, Fallot, & Harris, 2009; McWhirter, 2006). Additionally, research affirms the effectiveness of group therapy for trauma-related disorders. Most recently, results published from a meta-analysis of 152 studies on counseling outcomes for PTSD treatment indicated group work was as effective as treating clients individually (Erford, et al., 2016). Furthermore, literature supports various types of group approaches for women survivors of interpersonal trauma (Fritch & Lynch, 2008).

For example, in assessing the effects of an affect management (AM) group for female survivors of child sexual abuse, with PTSD. Zlotnick and colleagues (1997) found that women randomly assigned to the 15-week AM group ( $n = 16$ ) experienced greater reductions in posttraumatic and dissociative symptoms than women assigned to a waitlist control group ( $n = 17$ ). In a quasi-experimental study exploring the impact of process groups for female survivors of interpersonal abuse, Gorey, Richter, & Snider (2001) found women who participated in the group intervention experienced significant reductions in feelings of guilt, hopelessness, and isolation, as compared to women in the waitlist groups.

More recently, in a pilot randomized control trial examining Trauma-Informed Mindfulness-Based Stress Reduction for female IPV survivors, Kelly and Garland (2016) reported that women ( $n = 19$ ) assigned to the 8-week TI-MBSR group experienced statistically significant reductions in posttraumatic stress and depression symptoms than women in the waitlist control group ( $n = 20$ ). In addition, the magnitude of effect was large for pre-post changes in PTSD (Cohen's  $d = .94$ ) and depression (Cohen's  $d = .86$ ). An interesting outcome from this study was a statistically significant reduction in anxious attachment over such a short period of time. Though mechanisms of change were not explored, Kelly and Garland hypothesized that the focus on asking members to practice present-moment awareness in their relational experiences, during and outside of group, may have contributed to increases in adaptive interpersonal functioning.

Qualitative studies illuminate what women trauma survivors believe to be helpful aspects of the group interactive environment. For instance, women participating in a brief, intensive trauma treatment program reported participation in group therapy increased their feelings of interpersonal connection and empathetic understanding, as well as bolstered their confidence in developing relationships outside of group (Parker, Fourt, Langmuir, Dalton, & Classen, 2007). In addition, participants described psycho-education and skill-building components, including facilitator modeling, as helpful in supporting their learning and change processes (Parker et al., 2007). Similar experiences were reported by women who participated in a 17-week stabilization group. Group members reported the group experience as normalizing, validating, and helpful with gaining self-awareness and facing trauma-related issues (Stige, Rosenvinge & Træen, 2013).

In yet another qualitative study, interviews conducted with 18 women trauma survivors supported the curative elements of group work (Stenius & Veysey, 2005). In particular, interviewees described women-only, trauma-informed group environments as most beneficial, and they placed a great deal of importance on safety. Safety was created by the presence of an empathetic therapist and peer group, and these aspects of the group environment provided women with a greater sense of freedom to talk about trauma-related problems (Stenius & Veysey, 2005). Findings from these studies speak to the unique mechanisms of change present in group work approaches.

### **Therapeutic Factors in Group Work**

The primary difference between individual therapy and group therapy rests in the here and now interactions of group members (Yalom & Leszcz, 2005). These interpersonal processes are reflected in specific therapeutic factors; actions of the group leader, group members, or the individual that contribute to a client's psychological improvement (Bloch & Crouch, 1985). Yalom's classification system of group therapeutic factors is widely used to describe how group members change (Kivlighan & Kivlighan, 2014). He defined these factors as: instillation of hope, universality, imparting information, and altruism; the corrective recapitulation of the primary family group, socializing techniques, imitative behavior, interpersonal learning (input and output), cohesiveness, catharsis, and existential factors (Yalom & Leszcz, 2005). Important to note, this particular framework was influenced by the predominant theoretical paradigm guiding group psychotherapy practice at the time (Kline, 2003).

Taking into account the impact theory may have on the activation of therapeutic factors, Bloch and Crouch (1985) revisited the literature and developed an alternative taxonomy; one they believed to be more atheoretical (Kline, 2003). Their framework consisted of 10 factors

(Table 1): acceptance, altruism, catharsis, guidance, instillation of hope, learning from interpersonal action, self-disclosure, self-understanding, universality, and vicarious learning. (Bloch & Crouch, 1985).

### **Therapeutic Factors in Groups for Women Trauma Survivors**

Over the years, researchers have identified certain therapeutic factors that are relevant in group work for women trauma survivors (Bonney, Randall, & Cleveland, 1986; Randall, 1993; Sayin, Candansayar, & Welkin, 2013; Wheeler, O'Malley, Waldo, Murphey, & Blank, 1992). Early studies indicated women ranked the therapeutic factors of cohesiveness (Randall, 1993), catharsis (Wheeler et al., 1992), and self-understanding (Bonney et al., 1986) as most important. In a more recent investigation, Sayin and colleagues (2013) demonstrated linkages between therapeutic factors and client outcomes, such as reductions in PTSD symptomology.

Bonney, Randall, and Cleveland (1986) conducted one of the first studies exploring clients' perceptions of therapeutic factors in a group for women incest survivors. Participants' rank-ordered self-understanding, cohesiveness, and family re-enactment as the most important factors in their group experiences. The researchers noted these results differed from previous group therapy studies in which participants placed less importance on self-understanding and family re-enactment, indicating perhaps the group format, (i.e., a long-term, psychodynamic-interactive group), activates a specific set of therapeutic factors for women trauma survivors (Bonney et al., 1986).

Wheeler, O'Malley, Waldo, Murphey, and Blank (1992) also explored participants' perceptions of therapeutic factors in a time-limited group for women incest survivors. They were interested in determining which therapeutic factors were most salient for group members, and which factors were perceived most helpful over the course of the group experience.

Research participants were administered the Q-sort to rank order therapeutic factors. They also completed the CIQ after each group session. Three trained raters categorized statements from the CIQs into group therapeutic factors.

Results from the Q-sort indicated (1) catharsis, (2) self-understanding, (3) existential, (4) cohesiveness, and (5) hope were ranked as most important. These results differed somewhat from Bonney, Randall, and Cleveland's (1986) study, in which members ranked curative factors in the following order: (1) self-understanding, (2) cohesiveness, (3) family re-enactment, (4) catharsis, and (5) universality. Results from the raters' interpretations of 103 critical incident questionnaires indicated the most helpful factors were self-understanding, vicarious learning, acceptance, and self-disclosure. Furthermore, in sessions 1-10, members reported self-understanding, vicarious learning, acceptance, and self-disclosure as most helpful, while self-understanding, catharsis, self-disclosure, vicarious learning (tie), and acceptance (tie) were deemed most helpful in sessions 11-20 (Wheeler, et al., 1992).

In their discussion of the results, Wheeler and colleagues (1992) suggested differences between the two studies could be attributed to time-length (e.g., short-term vs long-term group), therapist characteristics (two female co-leaders vs a male-female team), and stage of group development. One result these studies had in common was participants' lower ranking of interpersonal learning, which may lend further support to the idea that specialized groups of this nature activate specific therapeutic factors. Another interesting aspect of this study was the researchers' inclusion of the CIQ; participants' responses indicated certain factors were more helpful than others, at different stages of the group experience. This raises the question of whether or not rank-ordering curative factors is the best method for determining which group components are most effective for women trauma survivors. Wheeler and colleagues generated

the following questions for future research: “Are incest survivor groups slow to develop trust and move through developmental stages? How much value is placed on family reenactment in time-limited groups with male-female co-leaders? Is the existential factor valued highly by other survivor groups?” (Wheeler et al., 1992, p. 94).

A more recent study conducted by Sayın, Candansayar, & Welkin (2013) explored the impact of group psychotherapy for Turkish women with sexual abuse histories. Researchers aimed to examine possible predictors of treatment adherence and response rates, as well as discover which group therapeutic factors were deemed most helpful by group members. The sample consisted of 47 women enrolled in a 12-session psychotherapy group for sexual trauma survivors. Each of the 5 completed groups consisted of 8-10 members. Participants were administered the Hamilton Depression Rating Scale (HAM-D), Hamilton Anxiety Rating Scale (HAM-A), Clinician Administered Post-traumatic Stress Disorder Scale (CAPS), Dissociative Experiences Scale (DES) and Childhood Trauma Questionnaire (CTQ-28). At the end of the final group therapy session, participants also completed the Group Therapeutic Factors Questionnaire (Yalom, 1975).

Results indicated participants’ experienced statistically significant reductions in depression, anxiety, and symptoms of post-traumatic stress, after the 6<sup>th</sup> session of group psychotherapy, and these reductions tended to be maintained at 6-months post-group. The therapeutic factors deemed most helpful by participants were existential factors, cohesiveness, and universalism. These results align somewhat with previous studies in which top-ranked factors included cohesiveness (Bonney et al., 1986; Randall, 1993) and existential factors (Wheeler et al., 1992). In their discussion of the results, Sayın and colleagues (2013) suggested cohesion may have been ranked higher because women were able to come early to group and

spend time with each other before the session started. Consequently, they may have developed a stronger sense of comradery through this unstructured time together. This is interesting given the shorter duration of the group, suggesting perhaps cohesion is not necessarily a function of group duration, but rather the group environment and overall structure. A limitation of this study, as well as a previous study (Bonney et al., 1986), is that researchers only gathered data about therapeutic factors at one time point; the end of group.

The studies mentioned above have been helpful in increasing understanding about which therapeutic factors are especially salient for women trauma survivors. Perhaps even more important, these studies highlight the variability that exists in measuring and reporting curative factors in group work. The group type (e.g., psychodynamic), duration, client and therapist characteristics, instruments used to measure therapeutic factors, and stage of group development, all had potential to impact members' perceptions of which therapeutic factors were present and viewed as most helpful. Furthermore, these studies relied primarily on rank-ordering therapeutic factors. Due to the inherent complexities associated with the assessment of group work processes and outcomes (Miles & Paquin, 2014), it seems appropriate going forward to gain a more in-depth understanding of how therapeutic factors are uniquely experienced by women in specialized groups for trauma survivors. Research suggests the unique features associated with equine-assisted activities can enhance group treatment for women survivors of interpersonal violence (Shambo, Seely, & Vonderfecht, 2010; Whittlesey-Jermone, 2014).

### **Women, Horses, and Group Work**

“Aesthetics and the beauty of nature heal all. I went into the outdoors to heal from my abuse.” (Stenius & Veysey, 2005, p. 1162). According to Stenius and Veysey (2005), some ways in which women trauma survivors have found solace and restoration are from being

outdoors, engaging in physical exercise, and spending time with companion animals. Such information is especially useful in conceptualizing the potential healing mechanisms associated with equine-assisted mental health (EAMH) interventions. In general, EAMH services are conducted in natural settings (i.e., ranch), often involve movement, provide relational experiences with a very socially engaging animal, and these interactions are guided by the presence of a qualified mental health practitioner (Hallberg, 2008). In regards to recovery from adverse experiences, trauma survivors have described the horse-human bond as a partnership of nonjudgmental acceptance and nurturance, which helps restore a sense of identity, as well as purpose, during the healing process. (Yorke, Adams, & Coady, 2008).

Anecdotal, conceptual and research articles, detail the benefits of equine-assisted interventions for women trauma survivors. Special emphasis is often placed on the horse's unique role in co-facilitating trauma recovery. As prey animals, horses' vigilance and flight behaviors are readily understood by women who have experienced abuse and no longer feel a sense of personal safety in the world (Meinersmann, Bradberry, & Roberts, 2008). Their sociability and interactive nature are believed to draw women out of isolation, strengthen the counselor-client therapeutic alliance, and facilitate interpersonal connection (DePrekel, 2012; Porter-Wenzlaff, 2007; Schroeder & Stroud, 2015). Further, women trauma survivors have reported that therapeutic interactions with horses are emotionally grounding, instill feelings of courage and hope, are helpful with reestablishing interpersonal boundaries, and developing assertiveness skills (Shambo, Young, & Madera, 2013).

Recent outcome studies suggest equine-assisted group interventions reduce trauma-related symptoms of psychological distress in women survivors. For instance, women enrolled in equine-assisted groups have experienced reductions in depression (Shambo, et al., 2010;

Signal, Taylor, Botros, Prentice, & Lazarus, 2013; Whittlesey-Jerome, 2014) decreases in dissociative tendencies (Shambo et al., 2010), increases in self-efficacy (Whittlesey-Jerome, 2014), and improvement in life functioning (Whittlesey-Jerome, 2014; Shambo et al., 2010). Though researchers are understandably keen to determine the significance of the horse's unique contribution, it is nevertheless important to explore how group interactive processes could also contribute to client improvements. For example, when levels of group interaction are manipulated, specific outcomes may be impacted, regardless of the horse's presence.

This appears to be the case in a study conducted on Equine-Assisted Therapy (EAT) for anxiety and posttraumatic stress symptoms (Earles, Vernon, & Yetz, 2015). In this study, Earles and colleagues (2015) assigned 16 adults to groups ranging from five to six participants. Although the EAT treatment was delivered in a group setting, the focus was on individuals' development of insight and mindfulness skills, rather than therapeutic processes associated with group interaction and feedback exchange. Specifically, participants were asked "to not comment on one another" (p. 151) during the group experience. The researchers believed this format may have led to a lack of change on an outcome measure assessing perceived levels of social support. Thus, despite the relational aspect of partnering with horses, it is possible group processes contribute something uniquely additive as well. As related to women's trauma groups, activation of group therapeutic factors in an equine-assisted setting may be especially important given the roles mutual support, understanding, and acceptance play in women's recovery from experiences of interpersonal violence (Stenius & Veysey, 2005). Along these lines, there does exist preliminary indications group work processes may enhance equine-facilitated group work.

For example, in a pilot study on equine-facilitated psychotherapy for women with trauma-related disorders, six women participated in a 10-session EFP group that blended equine-

facilitated activities, psychoeducation, and mutual support. Shambo, Seely, and Vonderfecht (2010) noted that beyond the equine-focused activities women “found in the group a human environment where they could be both authentic and safe, which encouraged affective congruence and was clearly just as meaningful to them as the work with horses” (p. 17). Additionally, in a study conducted by Whittlesey-Jermone (2014), six women survivors of interpersonal violence participated in an 8-session equine-assisted psychotherapy group. Observational field notes on group process suggested one of the factors influencing participant outcomes was mutual support.

Researcher observations were not focused specifically on therapeutic factors, however therapeutic factors such as universality, interpersonal learning, and cohesion may have evidenced, indeed. Observers noted, “exposure to women similar to themselves seemed to be a catalyst for insight into the role of isolation in their relationships” (p. 95) and “...their weekly conversations with each other indicated they felt part of a larger community – one where other people experienced similar situations” (p. 95). Participant journal excerpts also revealed the curative elements of group work. One participant wrote, “This is my first group experience and especially for today I am seeing how important it is to have friends to balance you and support you. To make you see you’re not so different from the world” (p. 93).

Research shows group work is an effective treatment for trauma survivors (Erford, et al., 2016; Sloan, Bovin, & Schnurr, 2013), and therapeutic factors contribute to women trauma survivors’ therapeutic outcomes (Sayin, Candansayar, & Welkin, 2013). Literature on best practices for women’s groups recommends using nontraditional methods (Kees & Leech, 2014). An innovative group work intervention gaining increasing attention, as well as demonstrating positive effects for women survivors of interpersonal violence, involves the use of equine-

assisted activities (Whittlesey-Jermone, 2014; Shambo et al., 2010). Equine-assisted group approaches currently lack strong empirical support; however, recent literature suggests relational activities with horses aid women in recovery from trauma (Meinersmann et al., 2008; Shambo et al., 2010; Signal et al., 2013). Our review of the literature also indicates group therapeutic factors may be present during these types of groups; however, to our knowledge, no formal research evaluations have been conducted on this topic.

Delucia-Waack (1998) once asked, “How does the interaction of group environment and a particular treatment approach influence the effectiveness of a group?” (p. 235). Delucia-Waack went on to argue that advancing group work research and better understanding how different types of groups work, requires researchers to explore facilitative elements of the group environment, rather than view group as merely the delivery mode for a particular intervention. Along these lines, research on group treatments for interpersonal violence survivors has suffered from an absence of studies evaluating group-level processes (Fritch & Lynch, 2008), and our review of relevant EAMH empirical literature indicates this holds true for equine-assisted group work studies as well.

Greenberg (1986) suggested that exploring session-level events is one way to elucidate the change process, and argued that investigators needed to move beyond reporting frequency data in process research, as this creates the illusion "that all behaviors are equivalent regardless of context, timing, appropriateness, and quality" (p. 7). This sentiment has been echoed in critiques of therapeutic factors studies in the group work literature (e.g. Kivlighan & Kivlighan, 2014). To date, no empirical studies have focused on therapeutic factors in equine-facilitated group work. As such, this study will contribute to the literature focused on therapeutic processes at play in equine-facilitated group work with women trauma survivors.

### **Study Purpose**

The primary purpose of this study was to discover what group therapeutic factors were present in women trauma survivors' meaningful experiences participating in equine-facilitated group psychotherapy, and how these factors presented over time. We selected a directed approach to qualitative content analysis (Hsieh & Shannon, 2005). This approach has also been referred to in the literature as deductive category assignment (Mayring, 2000) and involves applying a theoretically-derived categorization system to the coding process (Hsieh & Shannon, 2005; Mayring 2000).

### **Research Paradigm**

Critical realism (Bhaskar, 1975) was the philosophical paradigm grounding our methodology. Critical realism attempts to strike a balance between determinism and relativism. Reality is understood to be independent of individuals' subjective experiences, and causality in the social world exists as representative of underlying processes and mechanisms that cannot be directly observed, yet influence observable events (Cruickshank, 2012). These underlying processes are contingent upon context. In other words, critical realists rely on theory to understand the world, and theoretically-derived mechanisms are believed to be situation-dependent and mutable (Cruickshank, 2012). In regards to the focus of this study, we explored participants' most meaningful experiences through our understanding of the theoretical underpinnings of group interactive processes. We anticipated group therapeutic factors would be present in participants' accounts, yet how these factors emerged would be unique to this particular group approach. From a critical realist perspective, we cannot make objective claims about the linkages between therapeutic factors and what participants' believed was most meaningful about their experiences in EFGP, but rather offer up one possible way to understand

which underlying mechanisms occur in this type of therapeutic group environment (Cruickshank, 2012).

## **Method**

### **Study Background**

Data were drawn from an existing data set ( $N = 22$ ) gathered in 2014 and 2015 as part of a mixed methods investigation on Equine-Facilitated Group Psychotherapy (EFGP) for women trauma survivors. After institutional review board and Institutional Animal Care and Use Committee approval, volunteer participants were recruited via referrals from organizations and practitioners who work with women who experienced interpersonal violence. During the initial meeting, researchers' provided an explanation of the study, obtained informed consent, and conducted screening assessments. Inclusion-exclusion decisions were based upon the following: pregnancy, severe allergic reactions to the ranch environment, mobility issues that would prevent walking up to 25 yards unassisted, active substance use, or at risk to be a danger to oneself or others, as determined by responses to items in the Beck's Depression Inventory (BDI II; Beck, Steer & Brown, 1996) and the Trauma Symptom Inventory (TSI-2-A; Briere, 2011). Participants were then scheduled into one of three eight-week EFGP treatment groups and completed weekly self-report measures and a qualitative questionnaire about their group experience.

**Group Intervention.** Overarching goals of the EFGP approach were to assist participants with (a) increasing self- awareness, (b) exploring and modifying negative beliefs, (c) expanding coping and self-regulations skills, and (d) gaining interpersonal awareness and support. A detailed overview of this group approach is published elsewhere (Schroeder & Stroud, 2015). The treatment groups for the mixed methods investigation generally followed this format; however, sessions were three hours instead of two, and in one group, equine activities

were delayed until the second session. Equine-assisted interventions entailed observational activities (e.g., watching herd dynamics), horse care (e.g., grooming), and handling (e.g., leading). EFGP sessions were designed to begin with group discussion, transition to equine-assisted activities, then close with process discussion. All three groups were facilitated by the first author; a female, master's level counselor, who is certified as a PATH, International Equine Specialist in Mental Health and Learning (ESMHL). The lead counselor was assisted by a female co-leader for one of the groups. The co-leader was also a master's-level counselor with experience in providing equine-facilitated group work for women trauma survivors.

**Qualitative Assessment.** *Critical Incident Questionnaire.* The Critical Incident Questionnaire (CIQ; Kivlighan & Goldfine, 1991) is a qualitative instrument designed to assess group members' meaningful experiences as related to a group session. The CIQ consists of one open-ended question, with accompanying sub-prompts. Participants filled out the CIQ after each EFGP session. In order to capture unique aspects of the group, the CIQ was modified by adding "horses" to one of the prompts. Individuals were asked to provide written responses to the following: "Of the events which occurred in this group session, which do you consider the most important to you personally? What actually took place? (For example, were other group members, *horses*, facilitator/s involved)? If so, in what ways? Why was this important to you? What did you learn from this event?"

The CIQ has been used extensively for group work research. Previous studies employed the CIQ to explore members' perceptions of therapeutic factors (McWhirter, Nelson & Waldo, 2014; Nitza, 2011; Schwartz & Waldo, 1999), changes in members' perceptions over time (Brouzos, Vassilopoulos, Baourda, 2015; Kivlighan & Goldfine, 1991; Wheeler, O'Malley,

Waldo, Murphy, & Blank, 1992), and for comparisons studies (Colmant, Eason, Winterowd, Jacobs, & Cashel, 2005; Shechtman & Perl-dekel, 2000).

### **Data Analysis**

For the current study, cases from the original data set were selected if the research participant completed the 8-week EFGP treatment and returned the weekly questionnaires ( $N = 9$ ). The mean age of the participants was 44 years ( $SD = 13.27$ ), and all identified as Caucasian. Two-thirds of the participants reported having a college education ( $n = 6$ ). All participants identified as survivors of childhood abuse, two participants indicated intimate partner violence, and a majority also reported experiences of sexual abuse ( $n = 6$ ). Over half of the participants ( $n = 6$ ) had been in counseling for more than one year; four participants reported having had past experiences with group therapy, and six participants attended individual counseling sessions while involved in the EFGP intervention. Participants' prior experiences with horses ranged from minimal (i.e., less than 6 months in some type of contact with horses) to extensive (i.e., 5-10 years), owning, caring for, and/or riding horses.

63 CIQs (87% return rate) were analyzed from the nine participant cases. After an initial read-through of each CIQ, two documents were removed from the analysis because the participant's narratives described information unrelated to the CIQ prompts. Data were coded in alignment with established approaches (Mayring, 2000; Schreier, 2012). First, participants' handwritten CIQ responses were transcribed to word documents. The unit of analysis was defined as an entire CIQ report. Text within each CIQ was further divided into smaller segments of meaningful information, or "units of coding" (Schreier, 2012, p. 131). Units of coding were further distinguished from "context units" (Schreier, 2012, p. 133), those segments of text

material that would be useful in understanding a unit of coding. This process of segmentation ensured consideration of all material and consistency between coders (Schreier, 2012).

In order to assess whether or not units of coding were representative of therapeutic factors, we utilized Bloch, Reibstein, Crouch, Holroyd, & Themen's (1979) structured coding manual for categorizing therapeutic factors. The manual consists of definitions and coding rules for assigning therapeutic factors to qualitative material. Based upon this model, Bloch and colleagues grouped the factors into three broader categories; cognitive factors, reflecting group members' thinking processes; affective factors, involving emotional experiences; and behavioral factors, involving member actions. This coding system has been used in tandem with the Critical Incident Questionnaire (Hobbs 1989; Kivlighan, 2011; Kivlighan & Goldfine, 1991; Mackenzie, 1987; Pollack, 1993; Sodano et al., 2014). Initial reliability testing of the manual by Bloch et al. yielded Cohen's (1960) kappa coefficients of .062, .052, and .60, which were significant at the  $P < .001$  level, indicating moderate interrater reliability among each pairing of 3 raters. Subsequent studies using the manual have reported kappa values reflective of solid (Kivlighan & Mullison, 1988) and near perfect (Kivlighan & Goldfine, 1991; Pollack, 1993) interrater agreements. Though the validity of this instrument cannot be assessed beyond face validity, the moderate to high interrater agreement across multiple studies suggests the categories are clear and understood by the raters.

Prior to applying the predetermined categories to the full data set, we pilot-tested Bloch and colleagues (1979) manual by independently coding a sample of text (i.e., 10% of the total number of CIQs). We discussed discrepancies in our results and noted challenges with assigning one therapeutic factor to an entire CIQ (a coding rule that was indicated in the manual). Similar coding difficulties have been noted by others (Kivlighan, Multon, & Brossart, 1996; MacKenzie,

1987), thus we agreed to code CIQ reports for the presence of more than one therapeutic factor, so long as multiple factors were not derived from the same unit of coding.

Following our pilot coding session, we independently coded each CIQ report by reading the reports line-by-line, highlighting key units of coding, abstracting meaning, and assigning therapeutic factors to these segments of text. Over the course of five analytic meetings, we utilized an iterative process to discuss meaningful text passages, assess the applicability of the categorization system, modify categories, compare coding results, discuss differences, and reach consensus. Early in this process, it became apparent that the multiple interactive components occurring in these groups required additional modifications to the coding frame. Consequently, we adapted Bloch et al.'s (1979) category definitions to be inclusive of communication occurring between members and horses, as well as members and horse handlers.

During coding, we also identified segments of text that did not apply to the deductive categories. The emerging concepts suggested that the context of the equine activity (e.g., level of challenge involved), and equine-specific characteristics influenced participants' cognitions, feelings, and behaviors in ways that did not fit the definitions of therapeutic factors. These emerging concepts were set aside for future analysis.

### **Researchers' Disclosure Statement**

It is important for a researcher to acknowledge how his or her background could influence or bias the qualitative research process (Morrow, 2005). The first author is a lifelong horsewoman, professional counselor, and group worker who has provided counseling services to women survivors of interpersonal violence. She is also a PATH, International equine specialist in mental health and learning, and has previously facilitated EFGP for women trauma survivors. In addition, the current study is connected with her role in the research project from which the

qualitative data for the current study was derived. Specifically, her involvement entailed extensive periods of time interacting with study participants, from pre-screening assessments through delivery of the intervention. This type of prolonged engagement (Lincoln & Guba, 1985) is considered a form of trustworthiness; however, there is also potential for her greater amount of involvement to bias the interpretative process. Furthermore, her role as a researcher and mental health professional created a power differential, which could have influenced the focus of group discussions, as well as how participants chose to respond to the qualitative assessment.

The second author is an experienced group worker and group work researcher. He has been involved in the study of groups involving horses and humans since 2012. For the present dissertation study, he shared responsibility with the first author for coding therapeutic factors. In this capacity there was a dual role as he also served as the first author's academic advisor and dissertation chair. Attempts were made to establish and maintain an egalitarian relationship between the researchers, throughout the research process, given this inherent power differential.

As a research team, we brought the following assumptions into the process: (a) therapeutic interactions with horses are emotionally safe, comforting, and empowering, (b) group therapeutic processes provide something unique that horses alone cannot provide, and (c) supportive interactions among group members are necessary for equine therapy to provide optimal benefits for women trauma survivors in their daily lives. These assumptions guided data analysis in regards to the special focus on group therapeutic factors as potential aspects of members' meaningful experiences. Given the researchers' backgrounds and assumptions, trustworthiness strategies were utilized to ensure methodological decisions, data analysis, and

reporting processes captured the phenomenon under study (Elo, Kääriäinen, Kanste, Pölkki, Utriainen, Kyngäs, 2014; Lincoln & Guba, 1985; Morrow, 2005).

### **Trustworthiness**

Lincoln and Guba (1985) outlined four core areas researchers need to address when establishing the trustworthiness of their results: credibility, confirmability, transferability, and dependability. In consideration of the recommendations for qualitative content analysis (Elo, et al., 2014), the following procedures were conducted to strengthen trustworthiness of findings. Credibility was addressed through co-analysis of the data, peer debriefing, researchers' reflective commentary, discrepant case analysis, and memos. Confirmability involved maintaining an audit trail of research-related files (e.g., raw data, memos, coding documents, and debriefing notes), and linking participant quotations to categories. These measures were critical aspects of building trustworthiness, as reconstructing participants' experiences through the researcher's subjective lens, which includes biases and assumptions, can distort how raw data is interpreted (Lincoln & Guba, 2005). Dependability and transferability were established through detailed descriptions of the sampling method, participant characteristics, and data collection and analysis processes. These steps help readers assess applicability of the results across different populations and contexts, as well as replicate study procedures.

### **Results**

A summary of all therapeutic factors across sessions is presented in Table 2. The most frequently observed therapeutic factors were instillation of hope and self-understanding, followed by learning from interpersonal action and guidance, then acceptance. Least observed were altruism, self-disclosure, catharsis, universality, and vicarious learning. Table 3 contains a display of each therapeutic factor and representative quotes from participants.

### **Cognitive Factors**

Participants described important events in which they gained increased insight and self-awareness. The therapeutic factor of self-understanding was observed to be present in all but the last session of group. This factor was most frequently found during session two, as it accounted for nearly two-thirds (63%) of all factors coded. Instances of guidance from group leaders, fellow group members, and horse handlers were identified in participants' accounts of their most important session events, and were most frequently observed during session four. Universality was primarily noted during the first, sixth, and eight EFGP sessions. Instances of vicarious learning were more common in sessions one through three of the groups.

### **Affective Factors**

Experiences of hopefulness were observed to occur in each EFGP session, except session six. Instillation of hope was the most common factor coded in session eight (71%). The therapeutic factor of acceptance was most frequently observed in session one. Less frequently observed was the therapeutic factor of catharsis. Similar to vicarious learning, a majority of observations of catharsis occurred in sessions one through three.

### **Behavioral Factors**

Learning from interpersonal action occurred as early as the first session, and was identified in all but the second session of the groups. This factor was most prevalent (30%) in session seven. Self-disclosure and altruism were the least identified therapeutic factors in participants' CIQs. Self-disclosure was observed in two participants' CIQs; one instance was found in session one, and another example was found in session six. Altruism was found to occur in one participant's most important session events, on two separate occasions.

## Discussion

The main purpose of this study was to explore therapeutic factors present in equine-facilitated psychotherapy groups for women trauma survivors. We were able to identify all ten of Bloch and colleagues' (1979) therapeutic factors, which suggested that EFGP shares commonalities with more traditional forms (i.e., talk therapy) of group work. Self-understanding, instillation of hope, guidance, learning from interpersonal action, and acceptance were the factors most frequently observed in participants' CIQs. These findings indicate the purpose and goals of EFGP, and the therapeutic factors found, align with the literature's emphasis on the importance of hope (Srivastava, 2015), social support (Steninus & Veysey, 2005, Ullman, 1996), and psychoeducation (Kelly & Garland, 2016; Zlotnick et al., 1997) in women's trauma recovery processes.

In general, self-understanding was present when members wrote about group-as-a-whole structured activities (e.g., facilitator-led group mindfulness exercise), equine-focused interventions, and group discussions. Coding units reflective of self-understanding revealed some participants' understanding regarding aspects of their trauma-based responses. For example, one participant wrote, "I became more aware of cause-effect linkage between non-fear emotional states and my need to express/discharge or otherwise manage the intensity when overstimulated/overwhelmed". Universality occurred during group-as-a-whole or member-to-member interactions. For instance, participants reported important session events related to finding out that other members had similar trauma histories, or experienced similar feelings and beliefs about themselves.

Vicarious learning was observed during group-as-a whole equine activities and post-activity group discussions. Instances of instillation of hope were found across group

experiences. Participant accounts revealed hope through feeling accepted by their peers, or by recounting how they saw other members grow and change during the group experience. Other CIQs indicated hope occurred through accomplishing tasks while working with an equine partner. Catharsis was found to occur during group-as-a-whole activities and during contact with equine partners. For example, this factor was noted when participants described being in physical contact with the horses. Examples of learning from interpersonal action included expressing needs to the group as-a-whole, as well as asking for peers' feedback, despite concerns of how they might respond.

While observations of catharsis and self-disclosure were among the least frequent, we believe this is in part a function of our coding process. Namely, throughout the coding process, we discussed our independent rating results. Though we found numerous instances that could represent catharsis or self-disclosure, we often ruled out these two factors because of the operational definitions in Bloch et al.'s (1979) manual. For example, the definition of catharsis specified that emotional expressions leading to relief may have been previously difficult or impossible to express. The self-disclosure definition emphasized verbalizing in spite of fear, embarrassment, and overall difficulty doing so. Participants in this study did not evidence these aspects in their responses to the degree that would warrant classification. We believe assigning either one of these factors in that way would be a misstep, bringing too much of our own subjectivity into the interpretation process, and thus bias the findings.

Though we observed guidance to be present in many of the CIQs, this factor has not been given a great deal of attention in the literature (Bloch & Crouch, 1985), and has been rated as less helpful, or less important, in other types of trauma survivor groups (Randall, 1995). This could be related to group purpose and goals (e.g., guidance not emphasized), or because

quantitative measures were used to assess to factors at one point in time. On the other hand, this could be indicative of aspects unique to running equine-assisted groups with women trauma survivors. In other words, although this was a psychotherapy group and not a psycho-education group, educational activities were included (e.g., mindfulness exercises), and the equine-focused interventions naturally led to opportunities for group members to receive guidance. For instance, some group members reported receiving educative content from group leaders that pertained to managing trauma-based somatic experiences. Guidance was also noted to occur when participants were working with their equine partners, under the supervision of horse handlers (e.g., being instructed on how to adopt a more assertive posture while leading a horse).

Our analysis revealed that the therapeutic factors of universality, altruism, and vicarious learning were exclusively found in participants' descriptions of their time interacting with, or observing, other group members. These observations support previous research on factors that are unique to group therapy (Fuhriman & Burlingame, 1990) versus individual therapy (Holmes & Kivlighan, 2000), and provides a potentially important consideration relevant to equine-assisted groups. Specifically, in order for these therapeutic factors to be activated in equine-assisted groups, group leaders need to be intentional with structuring groups so participants can benefit from these factors. In other words, a group too heavily focused on individualized activities with horses versus group-as-a-whole activities, may limit participants' abilities to talk about their commonalties (universality), learn from observation (vicarious learning) and help one another (altruism).

In addition, acceptance was observed solely during member-to-member, and group-as-a-whole interactions. That is, participants wrote about feeling accepted by other group members. This is an interesting finding as related to the literature on equine-assisted interventions. Though

horses have been reported as providing unconditional acceptance (Bachi, 2013), this construct may differ from acceptance as it is operationalized in group work. For example, does acceptance by an equine partner result in the same outcomes generated by acceptance among group members? Or, is feeling accepted by a horse the precondition for socialization amongst group members, potentially leading to increased levels of cohesion in the group overall? The latter idea aligns with theoretical literature about the roles animals play in facilitating social processes between humans (Hart & Yamamoto, 2015).

We also found therapeutic factors varied across individuals who were in a group together. For instance, sometimes, therapeutic factors differed according to the events described by the participants. Additionally, if two participants described the same session event, we did not necessarily assign the same therapeutic factors to their CIQs.. Previous research findings (Kivlighan & Mullison, 1988; Shaughnessy & Kivlighan, 1995) have indicated that individual personalities could account for observed differences. For instance, in a study of participants' perceptions of therapeutic factors in counseling groups, Kivlighan and Mullison (1988) found individuals scoring as more affiliative on a measure of interpersonal behaviors emphasized the cognitive factor of self-understanding, while those who identified as non-affiliative placed more importance on behavioral factors such as self-disclosure.

Patterns occurred as therapeutic factors manifested over the course of the group. Early on (sessions one and two) instances of acceptance and instillation of hope were comparatively high. Furthermore, in alignment with Bloch and Crouch's (1985) previous assertions that universality typically occurs at the beginning of a group and encompasses a felt experience that is less likely to be articulated, we found universality to appear primarily during the first and last EFGP sessions. Interestingly, observations of self-understanding in session two, far exceeded all others.

This makes sense considering participants were new to the group and one another, while simultaneously engaging in new experiences, such as interacting with their equine partners. During the middle sessions of the group, a shift occurred with a rise in guidance and learning from interpersonal actions, while instances of self-understanding continued to present. Guidance was observed to occur most frequently during session four. This could be related to group members' engagement in task-oriented equine activities that involved more group leader and horse handler involvement.

We also observed a more instances of instillation of hope and learning from interpersonal action. This may illuminate a potential distinction between therapeutic factors in more activity-based groups and those found in verbal groups. Our groups included psychoeducational elements with opportunities to practice behavioral change. In a study on therapeutic factors in occupational groups emphasizing social skills, Falk-Kessler, Momich, & Perel (1991) found patients consistently reported instillation of hope, interpersonal learning-output (i.e., learning to use interpersonal skills), and cohesion as the most helpful factors in their group experiences. The authors suggested that in-the-moment opportunities to learn and practice skills creates an environment for developing feelings of competency and achievement, which they posited would naturally lead to more feelings of hopefulness.

### **Practice Implications**

In order to effectively lead groups, clinicians need to understand group-specific processes (Schechtman, 2007). For EAMH practitioners, this includes understanding the differences between group activities with animals and psychotherapy (Harel, 2013). How then, do equine-assisted group leaders bring together both the unique features of group work and therapeutic interactions with horses, in order to best serve IPV survivors? We offer some suggestions based

upon Kivlighan and Kivlighan's (2014) best practice recommendations for using therapeutic factors in group work.

**Choosing therapeutic factors and linking them to outcomes.** The empirical literature indicates therapeutic factors may differ in relationship to variables such as the type of group and client population (Kivlighan & Holmes, 2004). As such, EAMH practitioners need to consider what therapeutic factors they might focus on during facilitation of equine-assisted groups. For example, if the group's goals align primarily with providing cognitive support, group leaders can aim to facilitate the activation of factors such as vicarious learning and guidance, while deemphasizing the more insight-orientated factor of self-understanding (Kivlighan & Kivlighan, 2014). Specific to trauma groups for women, research indicates women benefit from experiences of emotional safety and validation, and expressions of care and concern (Parker et al., 2007; Stenius & Veysey, 2005). Thus, EAMH practitioners may consider planning women's groups to promote acceptance and universality.

It is important for group leaders to think about which therapeutic factors could promote client goal attainment (Falk-Kessler, et al., 1991). Exposure to acts of interpersonal violence have been linked to increased risk for myriad post victimization responses (Ferrari et al., 2016; Iverson et al., 2013; Jordan et al., 2010; Rees et al., 2011), and trauma groups for women often aim to address symptoms of anxiety, depression, or posttraumatic stress. Studies have identified links between certain therapeutic factors and client outcomes (e.g., Joyce, MacNair-Semands, Tasca, & Ogrodniczuk, 2011). Joyce and colleagues (2011) found instillation of hope was a significant predictor of changes in group therapy clients' symptoms of depression, anxiety, and overall distress. In the current study, we found instillation of hope to be present in participants' descriptions of time spent with other group members, as well as with the horses.

Trauma survivors have reported challenges with transferring interpersonal skills learned in therapy to their daily lives (Tummala-Narra, Kallivayalil, Singer, & Andreini, 2012). Given the highly interactive nature of equine-assisted groups, EAMH practitioners can promote therapeutic factors such as learning from interpersonal action, as a means to give group members concrete practice with interpersonal skills and behavioral change. Knowing which therapeutic factors might influence client outcomes, and when these factors are more likely to occur, can aid EAMH practitioners in structuring group experiences.

**Modifying aspects of the group environment.** There are numerous ways EAMH practitioners can adapt their facilitation style, the group structure, and/or aspects of the group climate to activate specific therapeutic factors. For instance, cohesion-building activities are important in the early stage of group (Corey, 2012). This can pose a challenge in equine-assisted groups if sessions are weighted toward group members spending individual time with horses. One way to address this issue is by utilizing group-as-a-whole equine activities. For example, observing herd dynamics as a group, or pairing off members to catch a horse in the field while having the rest of the group observe the activity. In addition, allowing ample time for group discussions before and after the activities provides members with opportunities to develop trust, rapport, and understanding (i.e., feelings of acceptance), as well as identify commonalities with one another (i.e., universality). These are features of the group therapy environment that women trauma survivors have reported to be especially important in their recovery processes (Parker et al., 2007; Stenius & Veysey, 2005).

Therapeutic groups create social microcosms reflective of members' interpersonal relationships in their everyday lives (Yalom & Leszcz, 2005). Ish-Lev & Amit (2013) suggested that animal-assisted interventions occupy a unique space between individual and group therapy

because dual foci can be addressed; the intrapersonal and interpersonal. As such, if one of the purposes of a group is to help members feel less isolated, as is often the case in trauma recovery groups, it is important that group leaders are mindful of how to use member-horse interactions in service of group interactive processes (i.e., shifting from the intrapersonal to the interpersonal) in order to help group members reconnect with other human beings.

More specifically, animals interact with us based upon how we behave toward them, and this allows clients opportunities to receive feedback about how they relate to others (Ish-Lev & Amit, 2013). This can be useful in the context of equine-assisted group work if leaders help members apply what they learned with the horses during their interactions with other group members. One example would be prompting a participant to share what she learned from an equine partner about her relational style, then later asking for the group-as-a-whole to share feedback with this person about how they experience her during group. This can be followed-up at another level by asking members to try out new ways of relating to each other during group sessions. Promoting authentic and honest communication between members of a group, and supporting members' reflective processes on what occurred during these interactions, is critical for change to occur to in group therapy (Yalom & Leszcz, 2005). Therefore, it is essential that leaders give clients opportunities to interact with each other, not just the horses.

### **Limitations**

The small sample size limits transferability of these findings to other client populations and types of equine-assisted groups. In addition, the group treatment approach, leadership style, group composition, and participant characteristics, could have contributed to the results. Furthermore, coding stayed close to the manifest content. For example, altruism was identified in a unit of coding, yet the participant did not describe details of her altruistic behavior, or say

much about the context in which she was experiencing altruism. Therefore, we could not interpret a deeper level of meaning from the material. This generally limits our ability to gain a more nuanced understanding of therapeutic factors from this data set.

Also important to note, our findings are positioned within our interpretations of members' most meaningful events, which differs from other therapeutic factor studies that asked group members to identify and rate therapeutic factors. Along these lines, our methodology and results do not permit us to dig deeper and draw conclusions between the frequency of reported factors and how important they were to group members. However, we believe it is essential to emphasize that less frequent observations of certain therapeutics may not mean these factors were less impactful. Another limitation was the questionnaire. Though open-ended, the prompts (e.g. "what did you learn") may have biased participant responses by directing them to focus narrowly on certain aspects of their experiences in the group.

### **Directions for Future Research**

This qualitative content analysis can provide pathways for future studies of equine-assisted groups. Replicating, then extending this study could serve to strengthen findings. For example, involving different equine-assisted groups and populations, and with different group leaders, as well as triangulating findings with well-validated therapeutic factors instruments. An important study could be one that addresses equine-related activities or relational connections as pre-conditions for the enhancement of group therapeutic factors.

Whatever the focus future studies on equine-assisted groups need to be very intentional in describing the group, purpose, type of group, participant characteristics, screening procedures, group curriculum and methods for evaluating. Methods for assessing group process and outcome

need to be careful and deliberate considerations. This has been identified as being crucial for advancing the field of animal-assisted activities and therapies (Fine, Tedeschi, & Elvove, 2015)

### **Conclusion**

This study adds new knowledge about therapeutic factors occurring in equine-facilitated group psychotherapy for women trauma survivors, and represents a first step toward more empirical investigations of group-level processes in equine-assisted group work. Self-understanding, instillation of hope, guidance, learning from interpersonal action, and acceptance were frequently found to present in participants' most meaningful experiences. Key findings from this study also support the notion that group work is more than a method for delivering counseling or psychotherapeutic interventions (Delucia-Waack, 1998). Essentially, when here and now, member-to-member interactive processes are present, group work can stimulate therapeutic factors that are not typically present during individual therapy.

Unique to EFGP was the varying types of interactions, relationships, and activities occurring across sessions, and our results indicated there were aspects of participants' experiences that could not be neatly categorized into the group therapeutic factors as they are traditionally defined in the literature. For instance, there were instances when catharsis, instillation of hope, learning from interpersonal action, guidance, and self-understanding were identified in participants' interactions with horses and horse handlers, as opposed to interactions with other group members. This is an important consideration related to the EFGP environment. EAMH practitioners with awareness of how these various relationships play out in equine-assisted groups will be better prepared to facilitate interactive processes and help members make meaning of their experiences.

## Chapter 2 References

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Table 1

*Therapeutic Factors and Definitions (Bloch et al., 1979; Bloch & Crouch, 1985)*

Therapeutic Factor	Definition
Acceptance	A group member's subjective experience of feeling a sense of belonging in the group. This factor operates when a member not only perceives warmth, understanding, and friendliness from group members, but also feels accepted, supported, and cared for by the group.
Altruism	Group members gain personal benefits (e.g., increased self-esteem; feels needed) from extending help and support to other members of the group.
Catharsis	Expression of feelings (positive or negative). This factor occurs when members releases intense feelings about life events outside the group, or about what is occurring in the here and now. This emotional release may result in a sense of relief. Catharsis differs from "the skill of being emotionally expressive" (Crouch & Bloch, 1985, p. 161), which would be more appropriately categorized as learning from interpersonal action.
Guidance	A didactic interaction in which a group member receives helpful information from the group leader (e.g., psychoeducation). This factor also operates when a group member receives direct advice/suggestions from the group leader or other group members.
Instillation of Hope	This factor is activated when a group member gains a sense of optimism about the group's potential to be helpful for accomplishing their treatment goals. Hope can arise from witnessing that other members are improving or experiencing benefits from participating in the group.
Learning from Interpersonal Action	Group members learn from "their attempts to relate constructively and adaptively within the group" (Bloch & Crouch, 1985, p. 246). This type of learning is specifically derived from active experimentation in the here and now of the group experience (e.g., using assertive communication or responding adaptively to feedback from others). Insight/learning gained stems from the group member's efforts to relate to others in new ways.

*(Continued on next page)*

*Therapeutic Factors and Definitions (Bloch et al., 1979; Bloch & Crouch, 1985) (Continued)*

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Self-Disclosure	This factor operates when a member shares personal information with the group. Such information may be difficult for the member to openly express as it represents aspects of one's life previously kept secret from others.
Self-Understanding	A group member learns something important about self. This may entail a better understanding of how she or he is experienced by others; the root cause of problems, or the reasons for current behaviors. Insight and greater awareness may be gained through feedback from other group members or the group leader.
Universality	A group member discovers other members have similar problems, which reduces feelings of isolation; the group member is no longer alone "with problems or feelings" (Bloch & Crouch, 1985, p. 188).
Vicarious Learning	When a group member benefits in some way from seeing the therapeutic experiences of other members, or through observing the group leader. This learning may manifest through identification with another member, or recognizing positive behaviors to imitate.

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Table 2

*Percentages of Therapeutic Factors Across Sessions*

Factor (%)	Session								Total
	1	2	3	4	5	6	7	8	
Acceptance	.22	.00	.08	.00	.18	.08	.10	.00	.10
Altruism	.00	.00	.08	.00	.00	.08	.00	.00	.02
Catharsis	.11	.13	.08	.00	.09	.00	.00	.00	.05
Guidance	.00	.00	.15	.43	.09	.08	.20	.00	.13
Instillation of hope	.17	.13	.15	.36	.18	.00	.20	.71	.22
Learning from interpersonal action	.06	.00	.15	.07	.18	.17	.30	.14	.13
Self-disclosure	.06	.00	.00	.00	.00	.08	.00	.00	.02
Self-understanding	.11	.63	.23	.14	.27	.25	.20	.00	.21
Universality	.17	.00	.00	.00	.00	.08	.00	.14	.05
Vicarious learning	.11	.13	.08	.00	.00	.08	.00	.00	.05

Table 3

*Number of Observations and Examples of Each Therapeutic Factor*

Therapeutic Factor	# of Observations	Examples
Self - Understanding	19	“After talking, I realized I don’t prepare for the outcome when confrontation is needed. I brace emotionally and wait for the ‘explosion’ to come”.
Guidance	12	“I was having problems and getting frustrated. [The group leader] reminded me to focus on the moment and nothing else. I was able to lift the front hooves after that”.
Universality	5	“I feel like meeting the horse was important in sparking our conversation, but hearing other people have similar experiences was great for me”.
Vicarious Learning	5	“Particularly when another group member had soft tears in her eyes. It validated that personal crying was okay. That I can let my personal wall down and cry for myself and my healing”.
Instillation of Hope	20	“It is possible for others to care about me and for me to speak what I am feeling and it be acknowledged in a compassionate way and not leave me feeling selfish for asking for what I want and need”.
Acceptance	9	“There’s a playful acceptance of the fact that my desire for one-on-one with the horse trumps my ease with people in the group. And I am not sensing any rejection or judgement about this truth”.

*(Continued on next page)*

Table 3

*Number of Observations and Examples of Each Therapeutic Factors (Continued)*

Therapeutic Factor	# of Observations	Examples
Catharsis	5	“This moved me to tears as well. For me, I think it was the acknowledgement of how much hurt there is in me still and how I want healing from it”.
Learning from Interpersonal Action	12	“I asked for something that would make me more comfortable and had my request granted. I learned that it is okay to ask for what you need and it can make life more pleasant if I speak up”.
Self-Disclosure	2	“I got the nerve to bring it up during closing group and the group responded with caring and no annoyance”.
Altruism	2	“I feel good when another person can confide in me about their feelings. It gives me strength if I can help, or just understand what they are saying”.

Chapter 3:

Equine-Assisted Mental Health Services: An Assessment of Group Work

Involving Humans and Horses

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### Abstract

Little is known about the current practices of mental healthcare professionals providing equine-assisted group work, or practitioners' beliefs about their confidence in applying group leadership skills with this type of group work. A cross sectional survey design was used to explore equine-assisted mental health practitioners' ( $N = 24$ ) group work education, training, practice experiences and leader self-percepts using the *Group Leader Self-Efficacy Instrument* (GLSI; Page, Pietrzak, & Lewis, 2001). Descriptive statistics and chi-square tests were used to analyze the data. Results indicated continuing education and group leadership experiences were associated with higher group leader self-efficacy scores  $\chi^2(1, N = 24) = 10.67, p = 0.001$ . Directions for future research are proposed, and practice implications are discussed.

*Keywords:* equine-assisted group work, group leadership, group leader self-efficacy

## Equine-Assisted Mental Health Services: An Assessment of Group Work Involving Humans and Horses

Group work is a widely-used and efficacious mental health treatment modality (Burlingame, Strauss, & Joyce, 2013; DeLucia-Waack, Kalodner, & Riva, 2014; McRoberts, Burlingame, & Hoag, 1998; Yalom & Leszcz, 2005). Furthermore, group work is more and more utilized to enhance innovative treatment approaches, such as body-oriented interventions (Langmuir, Kirsh, & Classen, 2012); art therapy (Schechtman & Perl-dekel, 2000); and outdoor, adventure-based approaches (Tucker, 2009). There also exists increasing literature support for animal-assisted interventions delivered in a group format (Dietz, Davis, Pennings, 2012; Lange, Cox, Bernert, & Jenkins, 2007; Perry, Rubinstein, & Austin, 2012). Advocates of the human-animal bond suggest creatures both great and small support human health and wellness, and their presence has been noted to reduce stress, facilitate social interactions amongst humans, and increase general feelings of happiness and wellbeing (Chandler, 2012; Brodie & Biley, 1999). Much of the scholarly literature references the benefits of dog-assisted interventions; however, there are progressively more mentions of equine-assisted approaches as well. Horses are highly interactive, social animals, and their inclusion in group work has been reported to enhance group interactional processes (Schroeder & Stroud, 2015),

Though equine-assisted group approaches are promoted by researchers and practitioners alike, there is an absence of literature indicating what types of mental healthcare professionals lead equine-assisted groups and in what ways group work principles are incorporated with equine-assisted activities. We know even less about equine-assisted mental health (EAMH) practitioners' competencies to deliver group work in this setting. Mental health fields, such as counseling (ACA, 2014; ASGW, 2008) and social work (AASWG, 2010), as well as

independent, multidisciplinary organizations (AGPA, 2007), recognize group work as a specialty area of service delivery, with ethical guidelines and standards for best practices. Due to the dramatic increase in equine-assisted learning and psychotherapy programs domestically and abroad (PATH, Intl., 2013), the emergence of group interventions in EAA/T research (Kemp, Signal, Botros, Taylor, & Prentice, 2014; Nurenberg et al., 2015; Shambo, Seely, & Vonderfecht, 2010; Trotter, Chandler, Goodwin-Bond, & Casey, 2008; Vidrine, Owen-Smith, & Faulkner, 2002; Whittlesey-Jermone, 2014), and the inclusion of group work in EAA/T educational literature (Chandler, 2012; Trotter, 2012), we believe a more in-depth investigation is warranted. Consequently, this study intends to explore multiple facets of group leadership and group practice in EAMH settings.

### **Group Leadership**

Group work processes can be enhanced by the presence of a skilled leader (Luke, 2014), and group leaders are considered to play an important role in both group processes and outcomes (Schechtman & Toren, 2009; Yalom & Leszcz, 2005). Effective leadership is grounded in part by the leaders' ability to foster group members' support for each other (Gladding, 1994, Kline, 2003). Kline (2003) captured the essence of effective group leadership, suggesting that "...leaders emphasize creating and maintaining a therapeutic environment, teaching members effective communication skills and tools for interpersonal learning, and structuring interaction so that members can learn from one another" (p. iii).

Effective group leadership involves the application of specific skills, interventions, and strategies to facilitate group interaction (Kline, 2003). Core facets of group leadership functions include executive management, caring, emotional stimulation, and meaning-attribution (Lieberman, Yalom, & Miles, 1973), as well as fostering support, drawing out, blocking,

modeling, linking, feedback, reframing, leader self-disclosure, and processing (Luke, 2014). Group leaders have the added challenge of applying these skills across multiple “levels of the group: a) the intra-individual level, (b) the interpersonal level, and (c) the group-as-a-whole level” (Tasca, Francis, & Balfour, 2014, p. 25).

Beyond clinical skills, effective group leaders possess certain personality characteristics (Corey, 2012). Specifically, emotional presence, courage, personal power, a willingness to confront self, sincere interest in others, authenticity, a clear sense of identity, enthusiasm, and a strong belief in the power of group process. Enthusiasm for the process could be considered a particularly important group leader trait, as expert group leaders have emphasized that their ability to embrace the complexities associated with group interactive processes, and even look forward to the unpredictability and challenges of group work, contributed to more self-confidence in facilitating groups (Rubel & Kline, 2008).

### **Research on Group Leadership**

Research findings affirm links between group leadership behaviors and group work processes and outcomes (Fuhriman & Burlingame, 1994; Lieberman & Golant, 2002). For example, group leaders influence aspects of group climate. More specifically, investigators have found that a productive group climate instills “a sense of constructive interpersonal investigation” (Johnson, Burlingame, Olsen, Davies, & Gleave, 2005, p. 310), and this productivity is believed to manifest as high levels of group member engagement, successful navigation of conflict and anxiety, and less avoidance (Mackenzie, Dies, Coché, Rutan, & Stone, 1987; Kivlighan & Angelone, 1992; Kivlighan & Tarrant, 2000).

Group leaders’ presence and intentionality with structuring group processes positively impact group members’ experiences. For example, Kivlighan and Tarrant (2001) found

significant associations between leader intentions, group climate, and client treatment satisfaction. Group leaders' ability to create a safe environment (e.g., demonstrate warmth, empathy, and support) connected with increased member engagement and positive treatment outcomes (Kivlighan & Tarrant, 2001). Group leader functions serve to establish interactional components, guide formulation of goals and objectives, impact group developmental processes, and influence members' expectations, to name a few (Wilbur, Roberts-Wilbur, & Betz, 1981).

In a study examining the effects of leader behaviors in professionally facilitated support groups, Lieberman and Golant (2002) found a link between the leadership functions of meaning attribution, management-structuring, and client outcomes. Results indicated that clients ( $N = 269$ ) experienced "lower depression, fewer physical problems, high well-being, and better functioning" (p. 272) when leaders facilitated feedback exchange; transfer of learning; structured the experience through time management; developed and maintained group rules, norms, and goals; and blocked harmful group member behaviors (Lieberman & Golant, 2002).

Indeed, the continued viability of group work practice is intimately connected with clients' experiences. Individuals leading groups possess a significant amount of social power (Smokowski, Rose, & Bacallao, 2001). Furthermore, their value systems, assumptions, and biases can influence many aspects of the leadership process, ranging from goal development to techniques used in session (Corey, Corey, Callanan, 1990). Thus, it is critical for group leaders to understand what clients perceive to be helpful or unhelpful aspects of their leadership (Smokowski et al., 2001). Practitioners' lack of group leadership skills can have deleterious effects for clients (Schopler & Galinsky, 1994; Smokowski, Rose, Todar, and Reardon, 1999).

For example, in a survey conducted by Smokowski and colleagues (1999), research participants ( $n = 33$ ) reported that group leaders played a significant role in their perceptions of

negative group events. Participants most frequently cited the leader behaviors of lack of support, criticism, confrontation, unhelpful feedback/advice, monopolization, and lack of competency, as contributing to damaging group experiences. To supplement and expand upon the quantitative results from this study, Smokowski, et al. (2001) employed content analysis to better understand group casualties. Interviewees identified two leadership styles as particularly damaging. For some participants, leaders' misuse of power and confrontational style led them to feeling humiliated and shamed, while others indicated group leaders' passive approach resulted in feeling unprotected and unsupported when conflicts arose during their group experiences (Smokowski, Rose, & Becallao, 2001).

Facilitating groups is a complex endeavor, requiring leaders to have a nuanced understanding of interpersonal communication, group dynamics, and developmental stages; cultivate personal attributes such as openness, courage, and enthusiasm for the group process; and effectively apply group leadership skills and interventions (Corey, 2012; Kline, 2003; Rubel & Kline, 2008; Yalom & Leszcz, 2005). Group leaders' successful navigation of the intricacies associated with group work practice requires self-confidence and a strong belief in one's capability to execute group leadership functions (Corey, 2012; Macgowan & Wong, 2015; Wilson & Newmeyer, 2008). Consequently, group work researchers have begun to explore the role of self-efficacy beliefs in group leaders' professional development.

### **Group Leader Self-Efficacy**

According to Bandura (1977), self-efficacy involves an individual's belief in his or her ability to initiate behaviors that will lead to successful outcomes. Generally speaking, self-efficacy beliefs influence the activities people choose, how much effort they invest in their endeavors, and levels of persistence (Bandura, 1977). In regards to learning and skill

acquisition, Bandura (1982) also suggested individuals' self-efficacy beliefs impact the degree to which individuals will initiate and continue with the learning process, despite challenging circumstances. Individuals appraise their levels of self-efficacy through mastery experiences, vicarious learning and social comparison, quality of feedback from others, and internal experiences (e.g., physiological and emotional reactions) (Bandura, 1997, as cited by Artino, 2012). Beliefs of low self-efficacy often accompany strong self-doubt, which consequently interferes with a person's motivation to persist despite setbacks and uncertainty (Bandura, 1982). Self-efficacy research has been extended to the helping professions. Leading the way are studies conducted in the field of counselor education and supervision. Counseling self-efficacy has been referred to as an individual's self-beliefs about his or her ability to effectively perform the duties of a professional counselor (Larson & Daniels, 1998), and research on this construct provides a foundation for better understanding group leaders' professional development as well.

Counselor self-efficacy is influenced by several variables, including the supervision environment (Cashwell & Dooley, 2001; Daniels & Larson, 2001), counselor disposition (Larson, et al., 1992), and education and training experiences (Soresi, Nota, & Lent, 2004; Tang, Addison, LaSure-Bryant, Norman, O'Connell, & Stewart-Sicking, 2004). For example, in an exploratory study assessing graduate students' ( $N = 116$ ) levels of counseling self-efficacy, Tang and colleagues (2004) found associations between students' total scores on the Self-Efficacy Inventory (S-EI; Friedlander & Snyder, 1983) and total amount of counseling course work ( $r = .59, p < .01$ ), number of internship hours ( $r = .47, p < .01$ ), and clinical instruction ( $r = .40, p < .01$ ). Beyond the amount of education and training, Soresi, Nota, and Lent (2004) discovered that types of training experiences also impact individuals' perceived levels of self-efficacy. In their study on Italian career service providers' levels of career counseling self-efficacy,

individuals with more training in career counseling demonstrated higher self-efficacy beliefs than their counterparts, regardless of total years of counseling experience. In addition, exposure to a specialized continuing education experience appeared to positively impact career counseling self-efficacy beliefs (Soresi, et al., 2004). Clinical supervision is also documented to be important in supporting a counselor's beliefs in his or her ability to perform counseling tasks (Cashwell & Dooley, 2001; Daniels & Larson, 2001; Wheeler & Richards, 2007).

For instance, Cashwell and Dooley (2001) found that counselors receiving supervision reported higher levels of self-efficacy as measured by the Counseling Self-Estimate Scale (COSE; Larson et al., 1992) than counselors who were not receiving supervision. Beyond the presence or absence of supervision, the type of supervisor feedback can impact efficacy expectancies. In a study assessing counseling students' responses to feedback about their clinical skills, Daniels and Larson (2001) hypothesized that positive performance feedback would result in higher levels of counseling self-efficacy, and negative feedback would have the opposite effect. Results indicated significant differences in how participants rated themselves; students receiving positive feedback scored higher on the COSE from pre-test ( $M = 147.64$ ,  $SD = 24.07$ ) to post-test ( $M = 154.68$ ,  $SD = 24.12$ ). Students receiving negative feedback reported lower self-efficacy from pre-test ( $M = 143.87$ ,  $SD = 16.08$ ) to post-test ( $M = 130.57$ ,  $SD = 21.74$ ).

### **Group Leader Self-Efficacy Research**

Recent qualitative findings suggest certain types of education and training experiences positively impact clinicians' confidence in leading groups. Specifically, counselors have reported that experiential group work training, practice with leading actual groups, observation of seasoned professionals, academic instruction, and supervision aided their professional development as group workers (Ohrt, Ener, Porter, & Young, 2014). Though empirical research

on the construct of self-efficacy, as related to group leadership, is only just emerging, it is reasonable to suggest group leaders' self-efficacy beliefs could be impacted by the same variables cited in the research on counseling self-efficacy. Page, Pietrazak, and Lewis (2001) were the first researchers to actively explore self-efficacy within the context of group work education and training. In developing an instrument to assess group leader self-efficacy, they argued that a group work trainee's self-efficacy beliefs could impact the degree to which he or she felt capable of navigating the complexities associated with leading groups.

Similar to the literature on counseling self-efficacy, group work research indicates education, training, and supervision experiences impact individuals' perceptions about their ability to successfully lead groups. For example, Wilson and Newmeyer (2008) found individuals (i.e., master's students, master's-level clinicians, doctoral students, and doctoral-level counselor educators) with one or more advanced training courses in group work reported feeling significantly more confident in applying core group work skills than those who had minimal or no introductory courses in group work. Ohrt, Robinson, and Hagedorn (2013) found that counseling students' group leadership self-efficacy, as measured by the Group Leader Self-Efficacy Instrument (GLSI; Page et al., 2001), increased significantly after participation in experiential training group experiences. In a study assessing the impact of a service-learning experience on counseling master's students' group leadership self-efficacy and multicultural competence, Midgett, Hausheer, and Doumas (2016) found students' ( $N = 20$ ) scores on the GLSI increased significantly ( $p < .001$ ) from pre-test ( $M = 161.25$ ,  $SD = 21.05$ ) to post-test ( $M = 179.40$ ,  $SD = 18.50$ ), and the effect size was large ( $d = -1.38$ ).

Regarding the role of feedback in counselors' self-evaluations, in a grounded theory study exploring group leaders' competency concerns, Okech and Kline (2006) found group leaders

placed a great deal of significance on their co-leaders' feedback, and well as group members' reactions to their interventions, when gauging their own effectiveness. Expanding upon the results of previous research on group leader self-efficacy, Springer (2016) found graduate students' counseling self-efficacy was positively impacted by supervisors' focused feedback on their group leadership skills. Taken as a whole, the literature indicates that opportunities to develop skills mastery through direct experience and practice, observational learning, and positive supervision and feedback experiences, influence group leaders' self-efficacy beliefs.

### **Equine Assisted Activities and Therapies**

Equine-assisted activities and therapies (EAA/T) have grown in popularity. Two leading EAA/T organizations each reported that an estimated 700 affiliated centers provide equine-assisted services to individuals in the United States and internationally (<http://www.eagala.org>; PATH, Intl. 2013). Broadly defined, EAA/T interventions are equine-assisted interactions structured to promote individuals' psychosocial, behavioral, and/or physical health (Latella, & Abrams, 2015; PATH Intl., 2016). Subspecialties include, but are not limited to, therapeutic riding, hippotherapy, equine-facilitated learning, and equine-facilitated psychotherapy (PATH, Intl., 2016). These modalities are differentiated from one another per the specific goals of the client population, intended outcomes, and the type of professional providing services. Equine assisted mental health (EAMH) services can be described as psychotherapy or counseling approaches involving trained horses, which are conducted by licensed/credentialed mental health providers (Latella & Abrams, 2015; PATH, Intl., 2016). These types of interventions are focused primarily on the “psychosocial/behavioral aspect of interacting with an equine...” (Latella & Abrams, 2015, p. 116). Equine-assisted activities (EAA) include common horsemanship practices such as grooming, leading, and riding; or more novel interventions such

as reflective round pen exercises. These activities are structured according to the practitioner's theoretical orientation and the client's treatment goals (Hallberg, 2008; Latella & Abrams, 2015).

### **Equine Assisted Group Work**

It has been noted in the literature that trained therapy animals are uniquely suited to assist counselors during group work facilitation (Chandler, 2012). More specifically, their presence in groups can strengthen cohesion, reduce feelings of isolation, illuminate group dynamics, and enhance group members' awareness of self and others (Chandler, 2012; Hanselman, 2001; Lange, Cox, Bernert, & Jenkins, 2007; Perry, Rubenstein, & Austin, 2012; Reichert, 1994). For instance, members in an adolescent anger management group reported that the presence of a therapy dog had a calming effect, which was helpful when opening up to the group, and especially when personal disclosures involved the expression of difficult emotions (Lange et al., 2007). In an exploratory pilot study on Animal Assisted Group Therapy (AAGT; Perry, et al., 2012), participant feedback indicated the presence of a therapy dog attracted individuals who might have otherwise avoided group therapy. Data from clinician observations indicated dog-assisted interventions promoted rapport-building, feelings of safety and acceptance, and member self-awareness (Perry et al., 2012).

The benefits of equine-assisted therapy delivered in a group format have also been described in the literature (Earles, Vernon & Yetz, 2015; Kemp, Signal, Botros, Taylor, & Prentice, 2014; Klontz, Bivens, Leinart, & Klontz, 2007; Pollack, 2009; Schroeder & Stroud, 2015; Shambo, Seely, Vonderfecht, 2010; Trotter, Chandler, Goodwin-Bond, & Casey, 2008; Vidrine, Owen-Smith, & Faulkner, 2002). The inclusion of horses in group work interventions adds a novel social component which allows group members opportunities for increasing self and other awareness (Chandler, 2012). Horses do not filter their reactions to human behavior;

they communicate their experiences of discomfort, pleasure, fear, pain, boredom, or excitement in the moment, and with congruence (Hallberg, 2008). Keeping these equine-related traits in mind can help equine-assisted group practitioners facilitate group members' interpersonal awareness and learning processes (Schroeder & Stroud, 2015).

For example, in developing and implementing an equine-assisted group counseling (EAC) program, Trotter and colleagues (2008) reported activities such as grooming sessions and teaching group members how to halter a horse helped youth build interpersonal awareness skills and self-control. In addition, team work activities, such as guiding a horse through an obstacle course without touching, coaxing, or talking, aided group members with improving their communication and problem solving skills, as well as managing feelings of frustration. Outcomes from data collected during the intervention phase indicated youth participating in EAC groups experienced statistically significant improvements across a number of domains, including social stress, self-esteem, aggression behaviors, and overall total social behavior (Trotter, et al., 2008).

Other practitioners have incorporated similar activities in equine-assisted groups for adults (Pollack, 2009; Shambo et al., 2010; Whittlesey-Jermone, 2014). For instance, in an equine-facilitated psychotherapy group program for women with complex trauma symptoms, psycho-education and meaning-making components were weaved into the equine-assisted interventions (Shambo, et al., 2010). Equine behavior observation, grooming, and leading activities involved members' focused contact and engagement with their equine partners. These interactive processes gave group members ample opportunities to practice body awareness, regulation of emotional and physiological arousal levels, and develop skills for interpersonal boundary management (Shambo et al., 2010). Results from Shambo et al.'s (2010) pilot study of

this group indicated the format had positive effects on participants' trauma-related symptoms, such as levels of depression and dissociation.

Little has been published regarding practitioners' beliefs about their ability to effectively facilitate group work in this setting. Prior to exploring these processes, a necessary first step is to assess the current state of equine-assisted group work practice. To date, only a few surveys have explored different facets of EAMH service delivery. One survey does provide us with preliminary information regarding group work in the EAMH field. In Gresham's (2014) national survey of equine-assisted mental health practitioners, just over half of survey respondents ( $n = 75$ ) indicated they felt clinically competent to deliver adolescent (56%) or adult (51%) group therapy. In this study, clinically competent was not operationalized. Thus, it is unclear how respondents evaluated themselves when deciding whether to identify as competent. In addition, it is unknown how many survey respondents practiced group therapy and chose not to identify themselves as competent. Without this information, it is difficult to understand the professional needs of clinicians practicing group work in EAMH settings.

Along these lines, counseling self-efficacy literature indicates counselors' self-perceived ability to be helpful is largely a function of education, training, and supervision experiences, and this holds true for group workers. Generally speaking, individuals across a number of mental health disciplines enter the field with only a basic understanding of group theory and practice, often lack specialized training in group membership and leadership, and have limited access to supervised experiences leading groups (Burlingame et al., 2007; Simon & Kilbane, 2014). Studies indicate group leaders desire more specialized training opportunities, especially related to facilitating group interactional processes (Kirsten, Butow, Price, Hobbs, & Sunquist, 2006; Wiggins & Carroll, 1993; Zordan et al., 2010).

Like group workers, animal-assisted mental health practitioners must demonstrate a specialized skill set, one that encompasses both general counseling skills and expertise in animal behavior, training, and care (Chandler, 2012; Fine, 2015; Stewart, Chang, & Rice, 2013). EAMH practitioners have the added challenge of facilitating safe and meaningful interactions between individuals and large, powerful prey animals (Hallberg, 2008). Thus, if EAMH practitioners regularly utilize group work approaches, it seems imperative to better understand their training backgrounds, the types of groups they lead, their levels of self-efficacy, and professional development needs. To our knowledge, the current study will be the first to provide an exploratory assessment of group work practice in the EAMH field.

In short, equine-assisted mental health interventions delivered in a group format have evidenced individual treatment gains (Kemp et al., 2014; Shambo et al., 2010; Whittlesey-Jermone, 2014); however, research in this area is scarce. We do know group work is an empirically-validated mental health treatment approach (Burlingame, Strauss, & Joyce, 2013; Delucia-Waak et al., 2014), and group leaders play a significant role in group work outcomes (Kivlighan & Tarrant, 2001; Shectman & Toren, 2009). We also know that group leaders' perceived confidence in leading groups is impacted by a number of variables, including training and supervision experiences (Macgowan & Wong, 2015; Orht et al., 2013; Springer, 2016). To date, we have limited understanding of how group work approaches are being utilized in EAMH settings, no information regarding what types of group work education and training experiences EAMH practitioners possess, nor their self-efficacy beliefs related to applying group leadership skills in this setting. This has important implications for the field of EAMH in terms of better understanding potential gaps in service delivery standards, as well as focusing future efforts on developing appropriate education and training opportunities for practitioners.

### **Research Aims and Questions**

The primary intent of this research study is to contribute new knowledge regarding the use of group work in equine-assisted therapy settings. Specifically, the purpose of this study was to (a) describe the characteristics of equine-assisted mental health practitioners who use group work; (b) understand characteristics of groups in equine-assisted mental health settings; (c) determine practitioners' group work education, training, and practice backgrounds; and (d) discover practitioners' group work training needs. Additionally, we addressed the following research questions:

1. How do equine-assisted practitioners rate their self-efficacy for leading groups?
2. Are there any differences in practitioners' levels of group leader self-efficacy as related to group work education, training, or practice experiences?

We used a cross-sectional survey design, as this method can be particularly helpful when a phenomenon is not yet well-understood (Heppner, Wampold, & Kivlighan, 2008), and when the discovery of associations can be helpful in guiding future studies (Mann, 2003). Results from this study could provide valuable information to help guide a progression of EAMH group work practice.

### **Method**

Volunteer participants ( $N = 24$ ) were mental health practitioners with current or past involvement in the delivery of equine-assisted mental health groups. A majority of respondents identified as female and Caucasian. Respondent ages ranged from 25-70 years old ( $M = 46.04$ ,  $SD = 13.73$ ). Most respondents indicated a master's level education; one respondent had a post-master's degree, and six respondents had doctoral degrees.

## **Instruments**

*Group Work in Equine-Assisted Mental Health Settings Survey.* Developed specifically for this study, the primary purpose of this 36-item survey (Appendix A) was to gather information about the characteristics of EAMH practitioners who utilize groups in clinical practice. Items were organized by three sections. The first section consisted of 12 items that asked respondents to report demographic information related to age, gender, and ethnicity, as well as to educational, and professional background information. The second section contained five items geared toward practitioners' group work education and leadership experiences, and the third section contained nineteen items specific to practitioners' professional experiences delivering equine-assisted groups. Two items were open-ended questions that asked respondents to provide narrative responses about (a) any challenges they had experienced leading equine-assisted groups, and (b) if they had any additional perspective they wanted to provide about leading equine-assisted groups in general.

Items were initially developed based on a review of previous survey research related to the practice of group work (e.g., Gerrity & Mathews, 2006), equine-assisted therapies (e.g., Gergley, 2012; McConnell, 2010), and empirical literature specific to assessing group work education and training (e.g., Steen, Bauman, & Smith, 2008). Four professionals with expertise in equine-assisted mental health and experience leading equine-assisted groups reviewed the initial draft of 32 items. The reviewers provided feedback on each item's congruence with the overall aim of the study, clarity and phrasing of items, depth of areas addressed, as well as any overall impressions. Reviewer suggestions were incorporated and were collectively geared toward improving content, wording, and readability of the items.

*The Group Leader Self-Efficacy Instrument* (GLSI; Page, Pietrzak, & Lewis, 2001). The GLSI (Appendix B) is a 36-item self-report measure designed to measure respondents' self-efficacious beliefs about group leadership. Items were constructed to capture three specific areas related to group facilitation: group leader use of micro-skills, process skills, and skills for diversity. Respondents rate items using a 6-point Likert-type scale ranging from 1 (strongly disagree) to 6 (strongly agree). The reliability and validity of GLSI scores has been established through factor analyses of scores from normative samples of graduate counseling students ( $N = 113$ ;  $N = 55$ , respectively; Page et al., 2001). Scores were deemed to be internally consistent ( $\alpha = .95$ ), and test-retest reliable ( $r = .72$ ). Discriminant and construct validity of the GLSI has also been reported (Page et. al, 2001). Use of the GLSI in several empirical studies published over the past four years (e.g., Ohrt, Robinson, & Hagedorn, 2013; Midgett et al., 2016; Zordan et al., 2015) provide additional support for the utility of this instrument as a psychometrically sound measure of group leader efficacious self-percepts. Cronbach's alpha based GLSI scores from respondents in the present study indicated good reliability (.83).

### **Data Analysis**

Descriptive statistics were used to report sample characteristics. Additionally, the first author analyzed the two open-ended questions by noting themes from respondents' statements, creating categories representative of themes, and assigning descriptive labels to each statement in order to sort response information into the categories. Results from this process were reviewed by the second author. Given the exploratory nature of this study, we did not have a priori predictions regarding the relationship between group leader self-efficacy and characteristics of our sample. However, based upon previous literature, we tentatively hypothesized that education and experience may be associated practitioners' levels of self-efficacy for applying group

leadership skills in equine-assisted groups. Post hoc, chi-square analyses were performed to assess whether differences existed between GLSI scores and certain EAMH practitioner characteristics. For significant findings we calculated a Cramer's *V* calculation to measure the strength of association between variables. A chi-square test for independence was determined to be the most appropriate, as our data met the following assumptions: (a) data in the cells was calculated as frequencies, (b) the categories for our variables were mutually exclusive, (c) each respondent contributed data to one cell only, (d) there were two variables measured as categories, and (e) our sample size was large enough (>20 cases) to ensure the values of the cell expected would be five or more cases in at least 80% of the cells, and no cells had expected cases of less than one (McHugh, 2013).

We selected the following variables for analysis: EAMH practitioners' amount of group work continuing education and group leadership experiences (with and without horses). We conducted five 2 x 2 chi-square tests in order to determine associations between respondents' continuing education, group leadership experience, and group leader self-efficacy. Continuing education and group leadership experiences were dummy coded and summed to form composite scores. Composite scores and GLSI scores were dichotomized using median splits (e.g., more/less; higher/lower).

## **Procedure**

Following Institutional Review Board approval, an invitation to participate in the study was posted electronically to EAMH-related social media discussion groups and professional list serves. Follow-up reminders to participate were posted, though not systematically. The posted invitation included a URL link for secure online access via Qualtrics, to the combined into one study materials: (a) cover letter explaining the research, (b) questionnaire, and (c) Group Leader

Self-Efficacy Instrument. To maintain participants' confidentiality, no identifying information, including IP addresses, was recorded. Data collection occurred between September 6, 2016 and October 18, 2016. Results were downloaded into Microsoft Excel for organization, and data analysis was guided by the Real Statistics Resource Pack software for Microsoft Excel (Zaiontz, 2016).

## **Results**

### **Participant Characteristics**

Participant characteristics are presented in Table 1. Nearly half ( $n = 11$ , 46%) of the respondents indicated professional counseling (e.g., LPC) as their primary area of clinical practice. Other professions included social work ( $n = 3$ , 13%), marriage and family therapy ( $n = 3$ , 13%), and psychology ( $n = 4$ , 17%). 13% of respondents ( $n = 3$ ) selected the "other" category. Respondents' practice status varied, with most identifying as licensed/credentialed clinicians ( $n = 15$ , 63%). Practitioners' post-degree clinical experience ranged from none ( $n = 3$ , 13%) to 20 years or more ( $n = 4$ , 17%).

Respondents' EAMH-related clinical practice characteristics are displayed in Table 2. Most respondents had 1 to 10 years of experience providing EAMH services; with a majority of practitioners having provided services at PATH International affiliated centers, or privately-owned horse properties. 75% of respondents ( $n = 18$ ) held specialty certifications specific to providing EAMH-related services, and six respondents (25%) reported having no certifications in this area. 38% of respondents ( $n = 9$ ) indicated "other" (e.g., PATH Therapeutic Riding Instructor).

### **EAMH practitioners' group work education, training, and leadership experiences.**

Respondents' group work education and training experiences are presented in Table 3. Of the 23 respondents who answered the question, a majority (87%) completed 1 to 3 group work courses during graduate school. 75% of respondents ( $N = 24$ ) reported having group work continuing education hours, and 63% of practitioners ( $N = 24$ ) reported receiving group theory and practice content during their EAMH-related continuing education experiences. Table 4 shows what respondents considered to be the most helpful continuing education experiences. More than half (52%) of respondents indicated experiential workshops. 26% indicated clinical supervision for leading groups. In terms of group leadership experience (Table 5), a majority of respondents ( $n = 23$ , 96%) had led groups without animal assistance, and just over half (54%) had led more than eight groups. Regarding group work specific to EAMH services, 63% of respondents had led more than eight equine-assisted groups.

**Characteristics of groups led by EAMH practitioners.** Characteristics of groups are displayed in Tables 6 and 7. On average, respondents led groups with six members ( $M = 6.54$ ,  $SD = 1.74$ ), and a majority of respondents ( $n = 20$ , 83%) indicated co-facilitating equine-assisted groups with a trained equine professional. In terms of co-facilitating with another mental health professional, respondents reported the following: "always" ( $n = 4$ , 17%), "most of the time" ( $n = 6$ , 25%), "sometimes" ( $n = 10$ , 42%), and "never" ( $n = 4$ , 17%). In addition, of 22 respondents, half indicated they had co-facilitated groups with a graduate student or pre-licensed intern ( $n = 11$ , 50%). Respondents' equine-assisted groups ranged in duration from 1 to 4 sessions to 20 to 24 sessions. The most frequently reported duration of an equine-assisted group was 5 to 8 sessions, and the most frequently reported length of group session was 1.5 hours. In addition, a large number of practitioners conducted open enrollment groups and brief intensives.

Respondents' primary theoretical/clinical orientation for conducting equine-assisted groups varied, with the three most frequently reported approaches being cognitive behavioral therapy ( $n = 10, 42\%$ ), solution-focused ( $n = 6, 25\%$ ), and person-centered ( $n = 6, 25\%$ ). Practitioners predominately led psychotherapy groups ( $n = 19, 79\%$ ), followed by psycho-education ( $n = 17, 71\%$ ), and counseling groups ( $n = 14, 58\%$ ). Respondents provided groups were provided for clientele across the lifespan, with groups for adolescents reported the most frequently ( $n = 22, 92\%$ ). Half of the sample ( $n = 12, 50\%$ ) provided groups for military personnel. Other populations included couples, families, and individuals with severe and persistent mental illnesses, incarcerated youth, and those on the Autism spectrum. 67% of respondents ( $n = 16$ ) reported populations not included in the item response options. For example, some practitioners led groups for youth at risk, other mental health professionals, and college students, to name a few. The most common presenting concerns addressed with equine-assisted groups were anxiety, depression, and trauma.

### **Group Leader Self-Efficacy**

GLSI scores of the overall sample ranged from 157 to 216 ( $M = 186.3, SD = 16.9$ ). Chi-square results showed no significant associations between group leader self-efficacy and continuing education  $\chi^2 (1, N = 24) = 2.67, p = 0.102$ ; number of groups led without therapy animal involvement  $\chi^2 (1, N = 24) = 0.18, p = 0.673$ ; number of equine-assisted groups led  $\chi^2 (1, N = 24) = 2.67, p = 0.102$ ; or group leadership experiences combined  $\chi^2 (1, N = 24) = 2.25, p = 0.133$ . There was a statistically significant difference between group leader self-efficacy and continuing education and equine-assisted group leadership experience combined  $\chi^2 (1, N = 24) = 10.67, p = 0.001$ . This association was strong (Cramer's  $V = 0.67$ ). Standardized residuals indicated that those with more group work continuing education and group leadership

experiences were disproportionately more likely to have higher group leader self-efficacy than those who had less of these experiences 95% CI [.34, .99].

### **Respondents' Comments**

Twenty-one respondents provided brief statements regarding what they found most challenging about leading equine-assisted groups. General themes centered on logistical issues such as the availability and qualifications of personnel assisting with groups, funding difficulties, and time constraints. Respondents also mentioned challenges associated with irregular attendance of group members and stimulating group interactive processes among members, while also incorporating horses into groups. Additionally, six respondents provided comments to the prompt, "What other information would you like to provide about leading equine-assisted groups?" The primary theme from respondents' comments was a call collaboration among peers in the field.

### **Discussion**

The main purpose of this study was to conduct a preliminary exploration of equine-assisted group work practice and assess EAMH practitioners' group leader self-efficacy. We found EAMH practitioners came from a number of mental healthcare fields, and a majority had received group-related course work before entering the field. An interesting finding was the sheer diversity of group leadership experiences among respondents. Respondents reported facilitating multiple types and lengths of groups, and led groups for a variety of age groups and client populations. Also interesting was respondents' answers to questions about co-facilitation partners. Most respondents indicated they facilitated groups with an equine specialist; however, 17% of the sample indicated they never co-facilitated with another mental health professional, and 42% reported "sometimes."

In equine-facilitated psychotherapy sessions, it is generally equine specialists (terminology varies amongst organizations) who are responsible for monitoring the safety of clients around horses, attending to the horse's welfare, and assisting mental health professionals with designing and implementing equine-assisted interventions (PATH, Intl., 2016b). Hallberg (2008) suggested that depending on the type of group (e.g., insight-based approaches like equine-facilitated psychotherapy), it is recommended that practitioners co-facilitate with another licensed/credentialed mental healthcare provider who has additional training to provide EAMH services, while having trained equine handlers on hand "to assist during specific activities of an EFP session which do not include deeply probing or insight-based reflections" (p. 289).

The chi-square analyses also produced some interesting results. First, the number of groups that respondents led without animal assistance was not significantly associated with GLSEI scores. This could be plausible given the widely accepted belief that additional, specialized knowledge and skills are necessary for conducting animal-assisted interventions (VanFleet, Fine, O'Callaghan, Mackintosh, & Gimeno, 2015). It follows that group leaders need actual practice gaining competencies specific to EAMH services to feel confident using core group leadership skills in this setting. For example, animal-assisted therapy practitioners need to have a solid understanding of species-specific behaviors in order to guide group process when a therapy animal displays unpredictable behavior (Harel, 2013). As such, we believed it was possible that EAMH practitioners' self-efficacy for using group leadership skills might be more related to the number of equine-assisted groups led.

However, contrary to what we expected to find, there was not a significant association between the number of equine-assisted groups led and GLSI scores. We also looked at respondents' combined amount of group leadership experiences (i.e., with and without horses),

which did not produce statistically significant results. This was more surprising, as previous studies have indicated that counselors found practice leading groups to be one of the most helpful aspects of their training experiences (Ohrt, et al., 2014) and practitioners' have reported that their confidence for leading groups increased with more group leadership experiences (Rubel & Kline, 2008).

Another aspect of group leader effectiveness is continuing education. The Association for Specialists in Group Work's (ASGW) guidelines for best practices in group work highlights the importance of professional development by recommending that "group workers remain current and increase knowledge and skill competencies through activities such as continuing education, professional supervision, and participation in personal and professional development activities" (ASGW, 2008, p. 114). Looking at respondents' continuing education experiences and their GLSI scores did not result in a significant association. Finally, we assessed respondents' continuing education experiences combined with their equine-assisted group leadership experiences. This produced a statistically significant association. This finding suggested practitioners' confidence for using group leadership skills might not only be a function of experience leading equine-assisted groups, but also having more group work continuing education. This highlights a need to further assess how these two variables could contribute to group leadership effectiveness in EAMH settings.

### **Education and Training Recommendations**

The EAMH field lacks widely accepted standards for training practitioners, and certifications that do exist tend to teach a specific model (Hallberg, 2008). While there is no question that gaining model-specific competencies is beneficial, an even greater area of importance is developing core competencies related to areas of counseling practice, including

group work. Without additional, specialized training in group work, practitioners may lack the awareness and skills necessary to effectively deliver groups in EAMH settings.

More than half of respondents in this study reported that experiential workshops would be the most helpful continuing education experience for leading equine-assisted groups, and previous studies have demonstrated that experiential activities can impact group leader self-efficacy (Midgett et al., 2016; Orht et al., 2013). What types of experiential activities could benefit EAMH practitioners? In relationship to building confidence, Ohrt et al. (2013) found that counseling graduate students' group leader self-efficacy increased significantly after participating as group members in either a 10-week personal growth group or a 10-week psychoeducation group. Furthermore, counselors have reported benefits from observing more experienced group leaders (Ohrt et al., 2014).

Developing trainings in which EAMH practitioners can participate as members in equine-assisted groups, while simultaneously learning from more seasoned group leaders, could be a valuable offering to include in graduate training programs, or post-degree certificate programs that provide an EAMH concentration. The ASGW (2000) training standards offer useful guidelines as well. Respondents in our survey indicated that they ran multiple types of groups, including psychotherapy, psychoeducation, counseling, and task/work groups. The association identifies these as areas of advanced practice and recommends group workers log at least 30 clock hours of supervised practice for psychoeducation and task/work groups, and at least 45 clock hours of supervised practice for counseling and psychoeducation groups (ASGW, 2000).

Regarding theoretical orientation, most respondents indicated they used individual models of psychotherapy, such as person-centered approaches or cognitive behavioral therapy to lead equine-assisted groups. Kline (2003) points out that,

leaders using a theory designed for individually focused counseling or therapy or those functioning without a theory suffer a serious disadvantage. These leaders have no guidance regarding what aspects of interaction are important or unimportant, no guiding concepts that can help them understand interactions, and no model to guide interventions (Shapiro et al., 1998). (Kline, 2003, p. 280)

Consequently, another consideration for designing continuing education experiences for EAMH practitioners would be to incorporate content on how to use group development (e.g., Interactive Group Development Theory; Kline, 2003) and group leadership (e.g., Focal Conflict Theory; Whitaker & Lieberman, 1964) theories to guide group leadership strategies.

Lastly, the presence of a trained equine specialist during group work can be especially beneficial if multiple participants are in the arena at the same time. Results from this survey revealed respondents had, on average, six participants in a group. It is reasonable to suggest that equine specialists could also benefit from specialized education regarding group work theory and practice, so as to better support the group leader and clients, as well as structure appropriate and safe equine-assisted activities.

### **Limitations**

The primary limitation of this study is the difficulty in sampling persons who lead equine-assisted groups. We were unable to report a response rate and do not know the degree to which the sample is representative of the larger population, which limits generalizability. Furthermore, the GLSI was administered at one point in time, which limits our ability to establish a temporal relationship (Heppner et al., 2008) between variables and determine if exposure to group work education and leadership experiences actually increase group leader self-efficacy. Finally, items in the GLSI could have led to response error. In other words,

participants might have made selections based upon what they believed would be socially desirable responses (Heppner et al., 2008).

### **Directions for Future Research**

To expand upon this study's findings, we suggest several directions for future research. First, findings from our study suggested continuing education and leadership experiences were associated with group leader self-efficacy. Future surveys could explore what types of group leadership and continuing education experiences EAMH practitioners have access to, and how they feel about the quality of these experiences. Since we only assessed group leader self-efficacy at one point in time, it is difficult to know how this particular element contributed to their current levels of self-efficacy for leading equine-assisted groups. A natural next step would be to use pre-post or repeated measures research designs to assess the differential effects of specific group leadership training strategies. Furthermore, as other researchers have noted, high group leader self-efficacy does not necessarily equate to competence or effectiveness (Ohrt, et al., 2013). Future studies could triangulate group leader effectiveness with perceived self-efficacy and client outcomes.

Qualitative interviews with EAMH practitioners could be helpful for developing a more nuanced understanding of what group leadership experiences look like in this setting; for instance, looking at the challenges group leaders experience and how they cope with these challenges, or how one develops confidence for leading these types of groups. Reviewing qualitative investigations, such as Rubel and Kline's (2008) grounded theory study of expert group leadership, could be helpful in providing a roadmap for design considerations (e.g., method of sample selection).

Researchers can also interview clients to better understand helpful or unhelpful aspects of their group experiences (Smokowski, et al., 2001). Knowledge of this nature would aid the field in better understanding the complexities associated with including horses in a group work environment. This information could be useful for designing appropriate groups, screening clients, and assessing outcomes. Qualitative research designs can also be valuable for identifying important practitioner competencies. For example, Stewart, Chang, and Rice's (2013) grounded theory study on the knowledge, skills, and attitudes of competent animal-assisted counseling practitioners led to the American Counseling Association's (ACA) recently adopted Animal-Assisted Therapy in Counseling Competencies (Stewart, Chang, Parker, & Grubbs, 2016).

Another focus area could be exploring when and how equine specialists are included in the group process. Group co-facilitation has its own complexities, rewards, and challenges (Okech, & Kline, 2005). The co-facilitation experiences of both mental health professionals and equine specialists is an area ripe for investigation. A related avenue for cross disciplinary research is assessing the impact of group activities on both humans and horses. Regarding the field of animal-assisted therapies overall, such information is critically needed to supplement the design and delivery of interventions, in order to protect the welfare of clients and animals (Ng, Albright, Fine, & Peralta, 2015).

### **Conclusion**

Equine-assisted mental health interventions, and animal-assisted interventions in general, are becoming more popular and increasingly available to the public (Hallberg, 2008; VanFleet, et al., 2015). However, information concerning the characteristics of practitioners who provide these services continues to be very limited. Results from this study provided an initial snapshot

of the practitioners who facilitate equine-assisted group work. Individuals in this sample represented several mental health professions and had varying amounts of group work continuing education and leadership experiences. In general, these practitioners felt confident about using basic group leadership skills in EAMH settings.

We do not yet know the degree to which practitioners' education and training experiences, and perceived self-efficacy, translate to competent service delivery. VanFleet and colleagues (2015) wisely asserted that blending animal-assisted interventions into one's professional practice is more complex than we acknowledge. Studies bridging the gap between training and practice is a necessary next step in the professionalization of EAMH services. Researchers can expand upon the findings in this survey by designing studies to assess more nuanced aspects of group work practice in EAMH settings.

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Table 1

*Respondent Characteristics (N = 24)*

Characteristic	<i>M (SD)</i>
Age	46.04 (13.73)
Gender	<i>n (%)</i>
Female	23 (.96)
Male	1 (.04)
Country	
United States	24 (1.00)
*Racial/ethnic identity	
Caucasian	22 (.92)
Hispanic/Latino	2 (.08)
Asian	1 (.04)
Education	
Masters (e.g., M.S., M.A., M.Ed.)	16 (.66)
Doctorate (e.g., Ph.D., Ed.D, PsyD)	6 (.25)
Other (e.g., Ed.S., Ph.D. candidate)	2 (.08)
Primary area of clinical practice	
Professional counseling	11 (.46)
Social work	3 (.13)
Psychology	4 (.17)
Marriage and family therapy	3 (.13)
Other	3 (.13)
Practitioner status	
Graduate student	3 (.13)
Post-degree, pre-licensed clinician	4 (.17)
Licensed/credentialed clinician	15 (.63)
Other	2 (.08)
Post-degree clinical experience	
None (currently student)	3 (.09)
Less than 1 year	2 (.08)
1-5 years	4 (.17)
6-10 years	7 (.29)
11-19 years	4 (.17)
20+ years	4 (.17)

Table 2

*Respondents' Years of EAMH Clinical Experience, Credentialing, and Primary EAMH Practice Setting. (N = 24)*

Experience	n (%)
Years providing EAMH services	
Less than 1 year	4 (.17)
1-5 years	10 (.42)
6-10 years	7 (.29)
11-19 years	3 (.13)
EAMH-related certifications <sup>a</sup>	
EAGALA certified MHP	7 (.29)
EAGALA advanced certified MHP	2 (.08)
EAGALA certified equine specialist	6 (.25)
PATH Intl. ESMHL	7 (.29)
Other certificate program	9 (.38)
None	6 (.25)
Primary practice location	
PATH Intl. affiliated center	10 (.42)
Privately owned horse property	11 (.46)
Public equine center	3 (.13)
Residential treatment facilities	4 (.17)
Other	3 (.13)

Note. Percentages are rounded and do not necessarily total 100%.

<sup>a</sup>Some respondents indicated more than one certification. Key;

MHP = Mental Health Professional

ESMHL = Equine Specialist in Mental Health and Learning

Table 3

*Respondent group work education and training experiences*

Experiences	<i>n</i> (%)
*Group work courses completed ( <i>n</i> = 23)	
None	2 (.09)
1-2 courses	12 (.52)
3 courses	8 (.35)
Other <sup>a</sup>	1 (.04)
Hours of group work continuing education ( <i>n</i> = 24)	
0 hours	6 (.25)
1-5 hours	6 (.25)
6-10 hours	2 (.08)
11-15 hours	1 (.04)
20+ hours	9 (.38)
Equine-assisted continuing education had group work theory and practice content ( <i>n</i> = 24)	
Yes	15 (.63)
No	6 (.25)
Not sure/unable to recall	2 (.08)

*Note.* Percentages are rounded and do not necessarily total 100%.

<sup>a</sup>Other: respondent indicated completing five courses.

Table 4

*Respondents rankings of most helpful group work education/training experiences for leading equine-assisted groups (n = 23)*

Type	n (%)
Experiential (i.e., hands-on) workshops	12 (.52)
Clinical supervision for leading groups	6 (.26)
Conference sessions	2 (.09)
Peer consultation groups	1 (.04)
Education materials	1 (.04)
Other	1 (.04)

*Note.* Percentages are rounded and do not necessarily total 100%.

Table 5

*Respondents Amount of Experience Leading Groups With and Without Equine Involvement*

Characteristic	<i>n</i> (%)
Total number of groups led ( <i>without</i> equine involvement)	
None	1 (.04)
1-4 groups	5 (.21)
5-8 groups	5 (.21)
9-12 groups	0 (.00)
13-16 groups	4 (.17)
17-20 groups	1 (.04)
More than 20 groups	8 (.33)
Total number of groups led ( <i>with</i> equine involvement)	
None	0 (.00)
1-4 groups	6 (.25)
5-8 groups	3 (.13)
9-12 groups	3 (.13)
13-16 groups	1 (.04)
17-20 groups	4 (.17)
More than 20 groups	7 (.29)

*Note.* Percentages are rounded and do not necessarily total 100%.

Table 6

*Characteristic of Group Led by EAMH Practitioners*

	<i>M (SD)</i>
Number of group members (i.e. clients, patients)	6.54 (1.74)
Types of groups led	<i>n (%)</i>
Psychotherapy	19 (.79)
Counseling	14 (.58)
Psycho-education	17 (.71)
Work/task	9 (.38)
Other	3 (.13)
Age range of those receiving services	
Children (12 years or younger)	11 (.46)
Adolescents (13-17 years)	22 (.92)
Young adults (18-25 years)	14 (.58)
Adults (26-64 years)	17 (.71)
Seniors (65+ years)	2 (.08)
Populations served	
Couples (i.e., multi-couple groups)	7 (.29)
Families (i.e., multi-family groups)	8 (.33)
Military	12 (.50)
Incarcerated youth	9 (.38)
Autism Spectrum	7 (.29)
Severe/persistent mental illness	10 (.42)
Other	16 (.67)
Presenting concerns addressed	
Anxiety	22 (.92)
Depression	22 (.92)
Trauma (includes trauma from interpersonal violence)	22 (.92)
Substance-related and addictive disorders	10 (.42)
Feeding and eating disorders	6 (.25)
Grief and loss	18 (.75)
Work/career-related	8 (.33)
Academic	8 (.33)
Other	5 (.21)

*Note.* Percentages are rounded and do not necessarily total 100%.

Table 7

*Overall Number and Length of EAMH Group Sessions (N = 24)*

Group Duration	Session length (in hours)							n (%)
	1.0	1.5	2.0	2.5	3.0	3.5	≥ 4.0	
Open enrollment	.40	<b>.53</b>	.13	-	-	-	.07	15 (.63)
Brief intensive	.08	-	-	-	.08	.17	<b>.83</b>	12 (.50)
1-4 sessions	.36	<b>.55</b>	.18	-	-	-	.18	11 (.46)
5-8 sessions	.22	<b>.67</b>	.17	-	-	-	.6	18 (.75)
9-12 sessions	.25	<b>.58</b>	.33	-	-	-	-	12 (.50)
13-16 sessions	.43	<b>.71</b>	.14	-	-	-	-	7 (.29)
17-20 sessions	.43	<b>.71</b>	.14	-	-	-	-	7 (.29)
20-24 sessions	.50	<b>.63</b>	.12	-	-	-	-	8 (.33)

*Note.* Percentages in bold indicate the most frequently reported length of session.

Multiple responses were permitted. Percentages exceed 100% and  $N > 24$  Key;

Open enrollment: continuous sessions with set number of sessions.

Brief intensive: Often a longer session length (e.g. half or full day) paired with a shorter overall duration (e.g. 2-3 days).

## Chapter 4

### General Conclusions

This chapter summarizes findings from two dissertation research studies exploring equine-assisted group work. The first study employed qualitative content analysis to explore therapeutic factors in equine-assisted group psychotherapy for women trauma survivors. Designed to assess aspects of group work practice in equine-assisted mental health settings and group leaders' self-efficacy beliefs, the second study utilized descriptive statistics to describe characteristics of group leaders and chi-square analysis to investigate associations between practitioners' group leader self-efficacy and their group work education, training, and practice backgrounds.

#### **Summary of Manuscript 1**

The first study was a qualitative investigation exploring therapeutic factors in equine-facilitated group therapy for women trauma survivors ( $N = 9$ ). Using a template for deductive category application, group participants' meaningful moments were analyzed for the presence of therapeutic factors and for how these factors occurred over time. Results indicated Bloch and Crouch's (1985) ten therapeutic factors were present, with instillation of hope, self-understanding, interpersonal learning and guidance were the most frequently observed factors in participants' accounts across the eight sessions. Findings suggested that the EFPG format can activate group therapeutic factors via traditional member-to-member interactions, and through more novel experiences with horses and other members of the treatment team (i.e., horse handlers). Participants' frequent mentioning of insights gained and hope derived from interactive components of the EFPG sessions, as well as the vital role others played in these meaningful moments, is very encouraging given the detrimental mental health effects (Iverson et

al., 2013; Jordan et al., 2010; Rees et al., 2011) interpersonal violence has on women trauma survivors. The primary limitations of this study was the small sample size, which created difficulties with making generalizations about the results. Also, our method of qualitative content analysis approach reduced our ability to conduct a deeper interpretative analysis of the data.

### **Summary of Manuscript 2**

The second study assessed the characteristics of equine-assisted mental health (EAMH) practitioners who deliver group work, including their perceived self-efficacy for using group leadership skills in this setting. The primary intent of this study was to conduct an initial exploration of equine-assisted group work, with a special focus on group leaders, in order to identify directions for future research efforts and potential new avenues for training EAMH practitioners. A web-based survey was administered to a convenience sample of EAMH practitioners ( $N = 24$ ). The survey included the Group Leader Self-Efficacy Instrument (GLSI; Page, Pietrazak, & Lewis, 2001), a 36-item self-report measure designed to assess group leaders' confidence in using core group leadership skills. Descriptive statistics were used to summarize key sample characteristics.

In general, EAMH practitioners who practiced group work came from different mental healthcare fields, including professional counseling, psychology, social work, and marriage and family therapy. Most practitioners received group work education during their graduate studies, and many had additional post-degree group work training through continuing education experiences. Survey respondents worked with a variety of age groups, client populations, and concerns. Respondents were most likely to treat clients presenting with depression, anxiety, or trauma.

Utilizing previous research on group leadership and the construct of self-efficacy, we also performed post hoc, chi-square analyses to assess potential associations between GLSI scores and practitioners' continuing education and practice experiences. Group work continuing education was not significantly associated with GLSI scores, nor was general group leadership experience (without therapy animal assistance) or equine-assisted group leadership experience. Surprisingly, overall group leadership experiences (with and without horses) was not associated with group leader self-efficacy.

The only significant association was between practitioners' combined group work continuing education and equine-assisted group leadership experiences. These results may suggest that the confidence to use core group leadership skills does not automatically transfer from one group setting to the next. EAMH practitioners may also need to develop the confidence to use specialized knowledge and skills specific to the equine therapy environment, as well as accumulate group work knowledge and skills through continuing education experiences. The primary limitations of this study were the small sample size and one-time administration of the instrument measuring group leader self-efficacy.

### **Combined Findings**

Group work has a long and rich history in the mental healthcare field (Scheidlinger, 2000), and has been helpful to a number of client populations, including women survivors of interpersonal violence. Beneficial aspects of group work are grounded in therapeutic factors, the unique mechanisms guiding group members' change processes (Crouch & Bloch, 1985; Yalom & Leszcz, 2005). How these factors are activated in any particular type of group is, in part, a function of the group leader. Through their knowledge of group interactive elements and stages of development, group leaders can utilize therapeutic factors to support the group process as it

unfolds and assist group members with addressing their treatment goals (Kline, 2003; Yalom & Leszcz, 2005). A group leader's ability to effectively support group therapeutic processes requires specialized knowledge and skills, as well as the self-efficacy to use these skills in a complex and dynamic clinical environment (Ohrt, Robinson, & Hagedorn, 2013; Page, et al., 2001). Researchers have begun to take a closer look at group leader self-efficacy, and studies suggest the confidence to use core group leadership skills increases with educative experiences and practice.

Findings from the first study suggested group work has potential to be a valuable treatment approach in equine-assisted mental health settings. The presence of group therapeutic factors in EFGP for women trauma survivors may indicate that this unique group work environment can provide the interactive components necessary for client change. Furthermore, results illuminated specific features of equine-assisted group work that promoted these factors. For instance, women's descriptions of their experiences interacting with horses (e.g., leading activities) revealed elements of self-understanding and learning from interpersonal action. Of equal importance, we found certain therapeutic factors (e.g., universality) were present exclusively when women talked about their interactions with other group members.

This has important implications for the EAMH field, and sheds light on ways to continue professionalizing EAMH services. Specifically, practitioners could benefit from education and training opportunities that teach them how to integrate group theory with the equine-assisted activities they choose to implement. The second study revealed EAMH practitioners had varying degrees of experience leading equine-assisted groups, as well as differing amounts of continuing education experiences. Survey respondents indicated that experiential workshops, supervision, and peer consultation would be helpful continuing education experiences for the groups they

lead. Hallberg (2008) noted that the highly experiential nature of equine-assisted group work approaches requires “extensive hands-on practice with the supervision of a professional skilled in facilitation of EFMH/ES prior to conducting this work for payment” (Hallberg, 2008, p. 258). We agree with these recommendations, and follow-up studies could dive more deeply into this topic by assessing the training and supervised practice experiences of EAMH practitioners.

Furthermore, while the second study did not assess EAMH practitioners’ level of competency to deliver equine-assisted group work, it is important to highlight the connection between self-efficacy and performance. In alignment with self-efficacy theory, Ringer (1999) suggested that group leadership competencies not only involve certain knowledge and skills, but also the ability to self-regulate one’s internal experiences in order “to retain access to those competencies” (p.16). Others echo this assertion, positing that emotion regulation, in particular, is a key aspect of effective group leadership (Champe, Okech & Rubel, 2013).

Findings from the first study on therapeutic factors in EFGP for women trauma survivors revealed that emotionally-laden content and expression of emotions happened as early as the first session. It has been noted that the inclusion of animals in psychotherapy has potential to heighten emotions quickly, and this can include the practitioner’s own emotional reactions to an animal’s behaviors (Hallberg, 2008; Parish-Plass & Oren, 2013). As mentioned in the preceding paragraph, group leaders’ ability to regulate their own emotional experience is important for maintaining cognitive access to leadership skills. It follows that EAMH practitioners leading groups must pay special attention to regulating their internal experiences, in light of the various interactive processes at play among horses and humans.

## Recommendations

We are only just beginning to understand how the inclusion of animals impacts the group work environment (Harel, 2013), and this reflects a larger issue in the field of equine-assisted activities and therapies, as researchers' have yet to identify clear and strong associations between specific components of the therapeutic process and client outcomes (Anestis, Anestis, Zawilinski, Hopkins, & Lilienfeld, 2014). The two studies in this dissertation provide new information about group processes and group leadership in EAMH settings, in turn producing new questions for future investigations.

The first study offers up new evidence regarding therapeutic factors in EFGP. More research is needed to better understand the connection between group therapeutic factors, equine-assisted activities, and group member outcomes. For instance, which therapeutic factors do clients identify as most helpful in equine-assisted groups, and how does this information connect with outcomes such as symptom reduction? In some of their recommendations for best practices in therapeutic factors research, Kivlighan & Kivlighan's (2014) suggested researchers (a) utilize well-validated therapeutic factors measures, (b) assess therapeutic factors over time with the use of longitudinal designs, (c) incorporate multilevel modeling to address the nested nature of group data (i.e., individuals nested within groups), and (d) triangulate findings by assessing the association between therapeutic factors and client outcomes.

The second study provided a snapshot of the practitioners who lead groups in EAMH settings. We know those with more group work continuing education and leadership experiences have higher scores in group leader self-efficacy; however, how this occurred is less understood. Follow-up surveys with larger, more diverse samples of EAMH practitioners would be helpful in assessing the nuances of group work practice in equine-assisted settings. Further hypothesis

testing of the relationships between group leader self-efficacy, group leadership competencies, and client outcomes is needed. Research is also needed to better understand practitioners' experiences facilitating different types of equine-assisted groups. Qualitative studies would be useful in exploring different components of the equine-assisted group leadership experience. Observational studies could be beneficial as well. For instance, field studies that include observer ratings of EAMH practitioners' use of group leadership skills, would be beneficial in identifying when and with what frequency these skills are being applied during group work with horses.

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## **APPENDICES**

## Appendix A

## Group Work in Equine-Assisted Mental Health Settings Survey

What is your age?

What is your gender?

- Female
- Male
- Other (please describe) \_\_\_\_\_

How would you describe your racial/ethnic identity? (multiple selections allowed)

- African American/Black
- Asian
- Caucasian
- Hispanic/Latino
- Middle Eastern
- Native American/Alaskan
- Pacific Islander
- Other (please describe) \_\_\_\_\_

In which country do you primarily provide equine-assisted mental health services? (click on the arrow to see a list of countries and select your answer)

What is your highest educational degree?

- Associate's degree
- Bachelor's degree
- Master's degree
- Professional degree (e.g., MD, DDC, JD)
- Doctorate degree (e.g., Ph.D., Ed.D.)
- Other (please describe) \_\_\_\_\_

What is your current status as a mental/behavioral healthcare practitioner?

- Graduate student
- Post/graduate, pre-licensed clinician
- Licensed/credentialed clinician
- Other (please describe) \_\_\_\_\_

What is your primary area of professional clinical practice?

- Professional Counseling
- Psychology (e.g., clinical or counseling)
- Social Work
- Marriage and Family Therapy
- Nursing
- Other (please describe) \_\_\_\_\_

What licenses and/or certifications do you hold in the mental/behavioral healthcare field? (e.g., LPC, LPC-Intern, MFT, LCSW, PNP, CDAC). (multiple selections allowed)

- License/s (please list) \_\_\_\_\_
- Certification/s (please list) \_\_\_\_\_
- Other professional credential/s (please list) \_\_\_\_\_
- None

What certifications do you currently hold related to conducting equine-assisted mental health services? (multiple selections allowed)

- None
- EAGALA Certification-Mental Health Professional
- EAGALA Advanced Certification-Mental Health Professional
- EAGALA Certification-Equine Specialist
- PATH International Equine Specialist in Mental Health and Learning (ESMHL)
- Certification Board for Equine Interaction Professionals-Certified Equine Interaction Professional-Mental Health (CEIP-MH)
- Other certification/certificate programs (please describe) \_\_\_\_\_

How many years of post-degree clinical experience do you have?

- None, currently a student (please indicate total number of practicum/internship hours completed) \_\_\_\_\_
- Less than 1 year
- 1-5 years
- 6-10 years
- 11-19 years
- 20 years or more

How many years of experience do you have providing equine-assisted mental health services?

- Less than 1 year
- 1-5 years
- 6-10 years
- 11-15 years
- 15-19 years
- 20 years or more

What is your primary practice location(s) for providing equine-assisted mental health services?  
(multiple selections allowed)

- PATH International Center (Accredited or Member Center)
- Privately owned horse property
- Equine center (e.g. public boarding and training facility)
- Residential facility (e.g., therapeutic boarding school, addiction treatment center) (Please indicate type). \_\_\_\_\_
- Other (please describe) \_\_\_\_\_

For the next series of questions, we would like to ask you about your education, training, and practice experiences in group work. For the purposes of this survey, Group Work is defined as "A broad professional practice involving the application of knowledge and skill in group facilitation to assist an interdependent collection of people to reach their mutual goals which may be intrapersonal, interpersonal, or work-related. The goals of the group may include the accomplishment of tasks related to work, education, personal development, personal and interpersonal problem solving, or remediation of mental and emotional disorders".

*Association for Specialists in Group Work (ASGW, 2000). Professional Standards for the Training of Group Workers*

What is the total number of group work theory and practice courses you completed during your degree program(s)?

- 0
- 1
- 2
- 3
- Other (please indicate) \_\_\_\_\_

Please indicate the extent to which you agree or disagree with the following statement: My degree program(s) adequately prepared me to lead groups.

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

How many groups have you led without equine (or other therapy animal) involvement? (actual groups, not number of sessions per group)

- None
- 1-4 groups
- 5-8 groups
- 9-12 groups
- 13-16 groups
- 17-20 groups
- More than 20 groups (please indicate approximate number) \_\_\_\_\_

Are you currently a member of any group work professional associations (e.g., the Association for Specialists in Group Work, the American Group Psychotherapy Association, or the Association for the Advancement of Social Work in Groups)?

- Yes (please list memberships) \_\_\_\_\_
- No

Approximately how many hours of continuing education in group work (e.g., understanding group dynamics, stages of group development, group leadership skills) have you completed? Please exclude any equine-assisted continuing education hours.

- 0 hours
- 1-5 hours
- 6-10 hours
- 11-15 hours
- 16-19 hours
- 20 hours or more

Did you complete course work in your degree program(s) related to the practice of equine-assisted mental health services?

- Yes
- No

If you answered Yes to the previous question, did your course work cover topics specific to applying group work principles (e.g. group leadership skills) in equine-assisted groups?

- Yes
- No

Please indicate the extent to which you agree or disagree with the following statement: I have been adequately prepared to lead groups in equine-assisted mental health settings.

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- Strongly agree

For the next two questions, please refer to the following descriptions of types of group work (ASGW, 2000; Corey, 2012)

**Psychotherapy groups:** Groups designed to assist members with gaining insight and awareness of maladaptive, often chronic, patterns of thinking, behaving, and relating to others, including correction of emotional or behavioral disorders, in order to improve personal and interpersonal functioning.

**Counseling groups:** Groups that help members with issues of human growth and development, wellness, and prevention, and temporary adjustment issues, in order to improve group members' personal and interpersonal functioning.

**Psycho-education groups:** Groups that impart factual information about a specific topic and provide group members with relevant skill-building opportunities. Examples of psycho-education groups include, but are not limited to, stress management, social skills, and population-specific topics such as domestic violence support groups.

**Task/work groups:** Groups that modify or enhance group member's functioning in relationship to specific work goals or outcomes. These types of groups often entail team-building and address issues related to organizational development.

What types of equine-assisted groups do you provide? (multiple selections allowed)

- Psychotherapy groups
- Counseling groups
- Psycho-education groups
- Work/task groups
- Other (please describe) \_\_\_\_\_

What types of groups do you lead most often in equine-assisted mental health settings? Please rank order options, with 1 being the type of group you lead most often and 5 being the group you lead least often. To rank the listed items, click on each item to drag and drop it in order of preference.

- \_\_\_\_\_ Psychotherapy groups
- \_\_\_\_\_ Counseling groups
- \_\_\_\_\_ Psycho-education groups
- \_\_\_\_\_ Work/Task groups
- \_\_\_\_\_ Other (please describe)

For the equine-assisted groups you lead, what is your primary theoretical/clinical approach (e.g., CBT, Person-Centered, etc.)? (please describe)

How many equine-assisted groups have you led? (actual groups, not number of sessions per group)

- 1-4 groups
- 5-8 groups
- 9-12 groups
- 13-16 groups
- 17-20 groups
- More than 20 groups (please indicate approximate number) \_\_\_\_\_

How often do you lead groups with the assistance of a trained equine professional? For example, an individual certified/trained through an equine-assisted activities/therapy certification program.

- Always
- Most of the time
- About half the time
- Sometimes
- Never



On average, how many people participate in your groups?

What age groups do you provide equine-assisted groups to? (multiple selections allowed)

- Children (up to age 12)
- Adolescents (13-17)
- Young Adults (18-25)
- Adults (26-64)
- Seniors (65+)

What populations do you provide equine-assisted groups to? (multiple selections allowed)

- Couples (i.e., multi-couple groups)
- Families (i.e., multi-family groups)
- Geriatric
- Military
- Incarcerated (Adults)
- Incarcerated (Youth)
- Autism Spectrum
- Severe/Persistent Mental Illnesses
- Other (please list) \_\_\_\_\_

What presenting problems do you treat with equine-assisted groups? (multiple selections allowed)

- Anxiety
- Depression
- Trauma, including exposure to interpersonal violence
- Substance-related and addictive disorders
- Feeding and eating disorders
- Grief and loss
- Work or career-related concerns
- Academic concerns
- Others (please list) \_\_\_\_\_

What do you find most challenging about leading equine-assisted groups? (please describe)

Have any of your equine-assisted continuing education experiences included information specific to group work theory and practice? (e.g., understanding group dynamics, stages of group development, group leadership skills)

- Yes
- No
- Not sure/unable to recall

What group work education/training experiences would be most helpful to you in your current practice? Please rank order options with 1 considered most helpful, and 6 considered least help. To rank the listed items, click on each item to drag and drop it in order of preference.

- \_\_\_\_\_ Clinical supervision for groups you lead
- \_\_\_\_\_ Conference sessions
- \_\_\_\_\_ Workshops (involving hands-on experiential components)
- \_\_\_\_\_ Peer consultation groups
- \_\_\_\_\_ Educational materials (e.g., books, videos, etc.)
- \_\_\_\_\_ Other (please describe)

What other information would you like to provide about leading equine-assisted groups?

## Appendix B

## Group Leader Self-Efficacy Instrument (Page, Pietrzak, &amp; Lewis, 2001)

Please answer the following questions based upon your experiences leading equine-assisted groups. Directions: Indicate the degree to which you agree or disagree with the following statements by selecting the appropriate response.

I am confident I can use my eyes to monitor group members

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can use my voice to set the tone of the group

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can change the focus from a topic, a person, or an activity to another topic, person, or activity

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can hold the focus on a topic, activity, or person

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can impart information or give mini lectures

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can draw out quiet members

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can cut off members

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can use rounds effectively

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can use linking to connect members

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can encourage expression of differences

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can give positive feedback

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can give corrective feedback

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can engage in appropriate self-disclosure

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can develop a clear purpose statement for the group

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can screen and select group members

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can conceptualize the group based on theory

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can provide an atmosphere of support and caring

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can provide structure for sessions (e.g., warm-up, action, closure)

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can help the group set productive norms

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can provide moderate emotional stimulation

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can make interventions based on the purpose of the group

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can make interventions based on theory

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can respond to the intrapersonal level of group process

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can respond to the interpersonal level of the group

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can respond to the group level of group process

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can respond constructively to an attack by the group

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can respond to a deep disclosure by a member near the end of the session

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can help members process the meaning of experiences

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can help members integrate and apply learnings

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can apply ethical and professional standards of group work

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can help members relate to other members of a different social class

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can help members relate to other members of a different sexual orientation

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can help members relate to others of a different ethnicity

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can help members relate to other members of a different race

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can help members relate to other members of a different age

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

I am confident I can help members relate to other members of a different religion

- strongly disagree
- disagree
- slightly disagree
- slightly agree
- agree
- strongly agree

## Appendix C

## Deductive Category Assignment Process

## Pilot coding: First read through of a critical incident questionnaire

1. Of the events which occurred in this group session, which do you consider the most important to you personally? Please describe: what actually took place? (For example, were other group members, horses, facilitator(s) involved? If so, in what ways?

[Being introduced to a horse all group members were allowed to touch [the horse] as part of our safety orientation. Particularly when another group member had soft tears in her eyes.]

Why was this important to you?

[It validated that personal crying was okay. That I can let my personal wall down and cry for myself and my healing. Especially crying with a horse as I am not yet comfortable with other humans seeing.]

What did you learn from this event?

[That I have a lot of personal healing and forgiveness to do. I've been avoiding myself for years. I learned to start meditating or mentally checking in. The few minutes I had just touching the horse had me feeling directly calmer after.]

Possible therapeutic factors: Vicarious learning, self-understanding



**Katy Schroeder**

Context: critical incident appears to be watching another member openly express emotion while working with one of the horses.



**Katy Schroeder**

Opening up in the group: this is the act of revealing self to others. Willingness to be open results from vicarious learning-seeing another person express emotions and benefiting in terms of own healing process-I can let my defenses down and experience emotions which I have been avoiding...



**Katy Schroeder**

Gaining self-awareness: becoming aware of ways of being in the world.

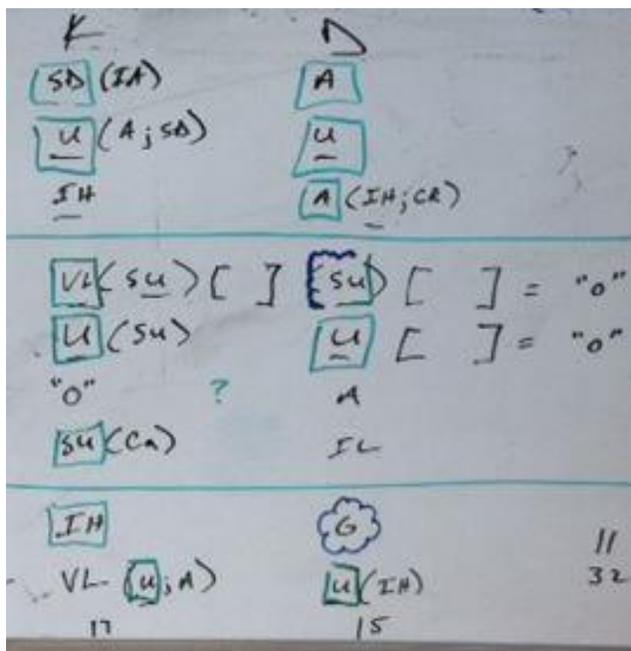


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Seems member has an additional critical incident? Or just noticing that the being around horses has a calming effect? Could be secondary to main CI.

**Memo:** I think I would tag this incident as primarily vicarious learning. Member did not cry, but rather felt a shift from watching another person in the group cry. Someone else experienced catharsis, and member learned that perhaps it's ok to let her guard down. Through this experience, member's self-understanding was heightened, though there doesn't appear to be a direct link. I think what she is saying is that she experienced some intense emotions-wanting to cry-from watching the other member and this increased her awareness that she has a lot she still needs to work through.

## Comparing Pilot Coding Results



### Pilot Coding Meeting Memo:

- Distinction between participants' most important event and observed therapeutic factors. Bloch et al., manual indicates assigning just one factor; what if they don't focus on one primary take-away? Can two factors hold equal weight? We would need more explicit information from the participants in order to rank one over the other and choose just one for the whole CIQ. At this point, seems ok to note that we might observe two factors instead of one (check literature; has this been done?).
- Question for next phase: What might constitute a coding unit as "other"?

### Example of Main Categorization Process: Session 1

Category	Operational Definition (Bloch et al., 1979)	Participant Case	Coding Unit
Instillation of Hope	-Sees that other group members have improved or are improving.	P3	That the possibility to heal is there within a group setting. That one can be within a group and not lose your identity, or be over-powered, and that one can remain intact.
	-Sees that the group can be of help to its members in working towards their goals.	P8	Knowledge is power and stepping out into new things can be scary, but also possible.
	-Feels optimistic about the group's potential for help. e.g. 'I am hopeful that, or feel that, the group will help me; I can see that the group is taking me somewhere'.	P9	I learned that group therapy can be helpful because you could have the same problem as someone else, but they can voice it and help you realize what is upsetting to you as well.

### Category Modifications Memo:

My thought going into primary coding of CIQs was that equine-related events, in which other group members were not watching or directly participating, could not be categorized under group therapeutic factors. I wanted to code these instances as “other. We discussed the human-equine dyad as part of the group therapy experience. Seemed similar to member-to-member interactions, which is certainly an aspect of group work. Same for group member-horse handler interactions. One of the biggest differences between EFGP and traditional group format is the physical layout. In a traditional (non-experiential) group, members sit in a circle, together the whole time, while in equine-assisted groups, physical proximity changes. Group-as-a-whole in the arena, yet dyads (member-horse) or triads (member-horse-horse handler; member-horse-group leader) are in different locations in the arena. Therapeutic factors are still at play. Reviewed coding units and agreed equine interactions involved an interpersonal, versus a purely intrapersonal process, including instances like these in the category assignment process, rather than separating them out as “other”, made sense moving forward.

Determining instances of guidance was a particularly sticky point. Guidance is narrowly defined in the Bloch et al., manual:

*-Receives useful information and instruction from the therapist about mental health, mental illness or general (not personal) psycho- dynamics.*

*-Receives explicit advice, suggestions, guidance about his problems from either the therapist or the other patients.*

Noted group work literature on the subject of guidance. Mackenzie (1987): "It would also be useful to have categories that are suitable for treatment approaches other than psychodynamic so that comparative studies could be done. For example, the present category of "guidance" does not do justice to more directive treatment approaches" (p. 32).

In the EFGP groups, participants were certainly getting guidance in various ways, but it was sometimes indirect in relation to addressing problems, and interactions between horse handlers and group members added another influence beyond group leaders and fellow members. We grappled with a question: does a group leader giving educative content about working with the horses technically qualify as the therapeutic factor of guidance? Unique part of EFGP is guidance through teaching equine-related skills; there's always a translational piece here; helping the client make sense of the equine-focused activity as it relates to what brought them to the group.

Also, looking at context, we could see that a horse handler giving instructions about how to work with a horse was reported to be helpful by some participants. We expanded the definition of guidance beyond what was in the Bloch manual. Guidance did not always have to be "explicit" and could come from the horse handlers. Looking at what the member wrote about receiving advice, suggestions, or instructions, helped us discern whether or not the group leader's or horse handler's support was useful to the participants in relationship to their problems/reasons for being in the group.

Appendix D

IRB Approval Documents



**Human Research Protection Program**  
*Institutional Review Board*  
 Office of Research Integrity  
 B308 Kerr Administration Building, Corvallis, Oregon 97331-  
 2140 (541) 737-8008  
[IRB@oregonstate.edu](mailto:IRB@oregonstate.edu) |  
<http://research.oregonstate.edu/irb>

**EXEMPT  
 DETERMINATION**

Date of Notification	08/10/2016	Date Acknowledged	08/10/2016
Principal Investigator	Daniel Stroud	Study ID	7613
Study Title	Group Work in Equine-Assisted Mental Health Settings		
Study Team Members	Katy Schroeder		
Review Level	Exempt	Category(ies)	2
Submission Type	Initial Application		
Funding Source	None	PI on Funding	N/A
Proposal #	N/A	Cayuse #	N/A

The above referenced study was reviewed by the OSU Human Research Protection Program (HRPP) office and determined to be exempt from full board review.

**EXPIRATION DATE:** 08/09/2021

The exemption is valid for **5 years** from the date of approval.

Annual renewals are not required. If the research extends beyond the expiration date, the investigator must request a new exemption. Investigators should submit a final report to the HRPP office if the project is completed prior to the 5 year term.

#### Comments:

##### Principal Investigator responsibilities:

- Certain amendments to this study must be submitted to the HRPP office for review prior to initiating the change. These amendments may include, but are not limited to, changes in funding, study population, study instruments, consent documents, recruitment material, sites of research, etc. For more information about the types of changes that require submission of a project revision to the HRPP office, please see:  
[http://oregonstate.edu/research/irb/sites/default/files/website\\_guidancedocuments.pdf](http://oregonstate.edu/research/irb/sites/default/files/website_guidancedocuments.pdf)
- All study team members should be kept informed of the status of the research. The Principal Investigator is responsible for ensuring that all study team members have completed the online ethics training requirement, even if they do not need to be added to the study team via project revision.
- Reports of unanticipated problems involving risks to participants or others must be submitted to the HRPP office within three calendar days.
- The Principal Investigator is required to securely store all study related documents on the OSU campus for a minimum of three years post study termination.



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<http://research.oregonstate.edu/irb>



Date of Notification	09/15/2016	Date Approved	09/15/2016
Principal Investigator	Daniel Stroud	Study ID	6268
Study Title	Researching Equine Facilitated Group Psychotherapy for Trauma Survivors: Horses and Humans in Therapeutic Relationship		
Study Team Members	Shannon Mattingly, Katy Schroeder, Dawn Sherwood, Monique Udell		
Review Level	Full Board, by expedited procedure	Category(ies)	N/A
Submission Type	Minor Change		
Waiver(s)	None		
Risk Level for Children	N/A		
Number of Participants	100 <b>Do not exceed this number without prior approval</b>		
Funding Source	Morris Animal Foundation	PI on Funding	Daniel Stroud
Proposal #	D14HA-010	Cayuse #	14-0558

The above referenced study was reviewed and approved by the OSU Institutional Review Board (IRB).

**EXPIRATION DATE:** 05/16/2017

Continuing review applications are due at least 30 days prior to expiration date

**Comments:** Study team member, Katy Schroeder, will use a portion of the qualitative data and analyses being conducted for this study, for her dissertation research

Please note when applicable, if the PI has not already done so, the HRPP staff will update the version date on the protocol and consent document(s).

**Principal Investigator responsibilities for fulfilling the requirements of approval:**

- All study team members should be kept informed of the status of the research.
- Any changes to the research must be submitted to the IRB for review and approval prior to the activation of the changes. **This includes, but is not limited to, increasing the number of subjects to be enrolled.** Failure to adhere to the approved protocol can result in study suspension or termination and data stemming from protocol deviations cannot be represented as having IRB Approval.
- Reports of unanticipated problems involving risks to participants or others must be submitted to the HRPP office within three calendar days.
- Only consent forms with a valid approval stamp may be presented to participants.
- Submit a continuing review application or final report to the HRPP office for review at least four weeks prior to the expiration date. Failure to submit a continuing review application prior to the expiration date will result in termination of the research, discontinuation of enrolled participants, and the submission of a new application to the IRB.