Healthcare provider perception and knowledge of equine-assisted psychotherapy:

A survey of providers in Oregon

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Abstract

A study was conducted to evaluate healthcare providers' knowledge and perception of equine-assisted psychotherapy (EAP). The knowledge transfer model was utilized to develop the project and to identify areas for future inquiry. For the study, a literature review was conducted and mental health specialists were queried to identify common misconceptions about the therapy. Out of this exploration, a survey was developed that asked questions specific to these fallacies. The project was vetted and approved by the Oregon Health & Science University institutional review board (IRB), an Oregon-based hospital's IRB, and the administration of a local clinic. The survey was then sent to approximately 650 medical and mental healthcare providers throughout the state of Oregon. Participation was voluntary and anonymous. At completion of the survey, the participants received an informational handout about EAP to save for their files. The survey yielded a 15% response rate. Results were compiled and released in aggregate form through SurveyMonkey and analyzed anonymously using SurveyMonkey tools. Descriptive statistics were displayed in chart form and compared responses to EAP questions with participant demographics. The survey revealed that the majority of healthcare providers were misinformed about how the therapy is conducted, how it is covered financially, how it varies from other animal-assisted therapies, and who conducts the therapy. Medical providers and those in practice more than 10 years were more likely to have misinformation about the treatment. Limitations of the study were addressed, and recommendations were made for future studies.

Keywords: equine-assisted psychotherapy, healthcare provider perception

Healthcare provider perception and knowledge of equine-assisted psychotherapy

Equine assisted psychotherapy (EAP) is a relatively new field that emerged in the late 1960s and merges the human-equine bond with theories influenced by Freud, Jung, and other cognitive, behavioral, and psychodynamic theorists (Lentini & Knox, 2009). The main body of equine therapy research began with hippotherapy, which utilizes horses for mobility rehabilitation (Lentini & Knox, 2009; Selby & Smith-Osborne, 2013). Over time, the benefits of using equine companions as co-therapists for emotional disturbances has emerged as a method of eliciting insights that may not be had by more traditional forms of talk therapy (Arlington Center, 2014; Lentini & Knox, 2009). EAP has demonstrated effectiveness in people with behavioral disturbances, trauma-related conditions, and neurodevelopmental disorders (Lentini & Knox, 2009; American Psychiatric Association, 2013). It has been shown to be effective for children who have been neglected, physically or sexually abused, or who have witnessed violence within their homes. Difficult to treat groups, such as “counselor-wise” youth, have also been responsive to this therapy (Lentini & Knox, 2009). In addition, EAP can be used in a variety of therapy settings, including individual, group, and family formats (Selby & Smith-Osborne, 2013).

Why Horses?

It is speculated that horses are highly effective in the therapeutic context because of their intuitive and social natures, large size, and sensitivity to body language and environment. In comparison to other animals used for therapeutic purposes, horses are unique in that they are prey animals and must be highly attuned to their environment (Frewin & Gariner, 2005; Lentini & Knox, 2009). For this reason, they are able to sense

incongruence between internal states and outward expression, and communicate back to clients in clear, immediate, and unhindered ways. This modeling by the animal can encourage open and direct communication from clients (Karol, 2007; Lentini & Knox, 2009; Trotter, Chandler, Goodwin-Bond, & Casey, 2008).

In addition, the horse's size may allow clients to explore issues of vulnerability, power, and control, as well as learn assertiveness skills over aggression or victimization (Lentini & Knox, 2009; Kohanov, 2001). Succeeding in gaining the cooperation of a thousand pound animal can enhance self-esteem and self-efficacy in other areas of a client's life (Trotter et al., 2008).

Enhanced client attendance, adherence, and retention in therapy are strong implications for using animal-assisted interventions as well (Kruger, Trachtenberg, & Serpell, 2004). Horses frequently have a positive impact on clients' motivation to participate in treatment, and investment by the client is one of the primary predictors of outcome (Frewin & Gardiner, 2005). This may be especially true for children and adolescents who rarely make a free and conscious decision to enter traditional therapy, but may find horses to be "a strong motivating force" (Karol, 2007).

Literature Review

A database search was conducted in Medline Ovid, Google Scholar, and Scopus using the key terms *horse therapy, equine psychotherapy, equine-assisted therapy, and equine facilitated psychotherapy.* A great deal of literature regarding hippotherapy resulted, so articles were selected based on abstracts that emphasized mental health care rather than physical disabilities. Reference pages of selected articles were also reviewed to identify auxiliary works. Through the resulting body of literature, no articles were

identified that linked equine-assisted therapy and medical provider perspectives on EAP. However, animal-assisted therapy was identified as a complementary treatment strategy in the literature, so an additional search was completed in Google Scholar and Medline Ovid using the combined key terms *complementary and alternative medicine* OR *complementary therapies, and perspective OR perception AND western medicine*. The "find similar" tool was used to identify additional articles appropriate for use.

Terminology

Many terms are used to describe therapeutic interventions involving horses. In addition, equine-related interventions are placed under the greater umbrella of animal-assisted interventions, which include both animal-assisted activities and animal-assisted therapy. This menagerie of descriptors is problematic for gaining acceptance in the greater medical community (Kruger et al., 2004). For the purposes of this paper, equine-assisted psychotherapy (EAP) will be used to describe the specific intervention of experiential psychotherapy using horses that is facilitated by a licensed and credentialed mental health professional dually credentialed as an equine professional or working with an equine professional (Kruger et al., 2004).

EAP as Complementary and Alternative Medicine

EAP is based upon accepted theoretical orientations within the psychiatric community, practiced within established treatment approaches, and can be used as a stand-alone modality; however, the therapy is considered a complementary and alternative medicine (CAM) treatment due to the non-traditional use of the horse within these conventional parameters (Masini, 2010; Morrison, 2007; Kruger et al., 2004; Klontz et al., 2007). The implications of this designation must be addressed, as

understanding of CAM therapies are hindered by a variety of barriers. Though there has been a shift toward greater acceptance of CAM in recent years, concerns still remain and may serve as a barrier to utilization (Wong, Han Sim Toh, & Kong, 2010).

Concerns and Misconceptions Regarding EAP

Priority concerns with CAM treatments include limited research regarding efficacy and safety and high out-of-pocket expenses (Pan et al., 2012; Stoneman, Sturgis, & Allum, 2012). In regard to EAP, these concerns can be specifically viewed as: (1) lack of randomized controlled trials; (2) higher cost of treatment compared to traditional forms of psychotherapy and medication management; (3) ethical dilemmas related to animal wellbeing, client privacy, and healthcare equity; (4) safety concerns regarding experiential treatments involving large animals; and (5) provider knowledge deficit regarding qualified EAP providers and appropriate populations for this type of treatment (Lentini & Knox, 2009; Selby & Smith-Osborne, 2013; Kaczorowski, Patterson, Arthur, Smith, & Mills, 2002).

Research evidence. Though multiple studies have been completed that demonstrate improvement in symptoms for a variety of populations, one of the main criticisms of research on EAP and animal-assisted therapies is the weakness in study design. Limitations that have been noted in these studies include small sample size, lack of randomization, inadequacy or absence of a control group, selection bias, informant and experimenter bias, poor generalizability, attrition rates, absence of reported novelty effect, and unknown long-term outcomes (Morrison, 2007; Holmes, Goodwin, Redhead, & Goymour, 2012).

***Two noteworthy studies*.** Despite these weaknesses, animal-assisted therapies have been implemented in a wide variety of mental health settings with diverse populations of clients, and the more rigorous study designs have revealed promising results. For instance, a study comparing the efficacy of group equine-assisted counseling for at-risk children and adolescents to an empirically supported in-school treatment program showed significantly greater improvement in those who attended the equine-based program. Participants of the equine program showed improvement in 17-targeted areas, whereas the comparison group showed improvement in five (Trotter et al., 2008; Selby, 2009).

Additionally, a randomized controlled trial was completed to evaluate the effects of an 11-week equine-facilitated learning program on salivary cortisol levels in fifth through eighth grade children. The study included 113 participants who were assessed at pretest and posttest intervals. Compared to the children who were waitlisted, those who received the intervention had significantly "lower total cortisol concentration per waking hour" (Pendry, Smith, & Roeter, 2014). This study was conducted in light of a previous study of racially-diverse school-age boys demonstrating that higher afternoon cortisol levels was linked to increased internalizing symptoms, as well as a study of adolescent boys and girls that linked higher morning cortisol levels to persistent depression (Pendry et al., 2014; Tyrka et al., 2010; Goodyer, Herbert, & Tamplin, 2003).

Each of these studies demonstrated statistically significant improvement in symptoms and have been identified as the most rigorous in design within the EAP body of research. The first study received a moderate level of research quality, which is noteworthy given "this is the highest level that can be achieved for observational studies using GRADE criteria" (Selby, 2009). The latter study was more rigorous in design, but

still reported a moderate treatment effect due to the limited research demonstrating long-term effects of altered cortisol levels in the adolescent population and because of the lack of severity in symptomatology of the participants (Pendry et al., 2014). Overall, more studies of this nature are needed in the field, but preliminary research is promising.

Financial coverage. Financial coverage for CAM is also a concern, especially considering the high cost of medical treatment today and the scaling back of benefits by insurance companies (Brill, 2013). Primary concerns are the cost of care for the animal and the need for an equine specialist to participate in the treatment, as both must be considered in the cost of treatment (Morrison, 2007). In addition, there are no billing codes for animal-assisted therapies, let alone codes that specify the type of animal incorporated into treatment (Morrison, 2007). This is problematic because the types of animals used require different levels of care. For instance, caring for a small animal, such as a dog or a cat, is much less expensive than caring for a large animal, such as a horse.

Given that horses are more expensive to keep, it is not surprising that as recently as 2007, insurance companies would not cover EAP (Karol, 2007). However, insurance companies are increasingly recognizing EAP as an accepted form of treatment, and though payment does not include the cost of care for the animal, the sessions are often third-party billable (Morrison, 2007). This is especially true if credentialed providers submit a treatment plan with progress notes documenting the advancements made in therapy and the resultant outcomes (Bachi et al., 2011). Additionally, because EAP is based on evidence-based approaches to care, such as cognitive-behavioral therapy and solution-focused therapy, providers are able to bill using standard CPT codes (EAGALA, 2013).

Insurance companies are more willing to cover treatment costs if published trials demonstrating efficacy are submitted for review (United Healthcare, 2014). The recent study by Pendry, Smith, and Roeter (2014) is a prime example of research that would be acceptable to insurance companies, as it demonstrates "causal effects on physiological outcomes associated with current and future physical and mental health."

Ethical issues. Another concern that arises is the ethical nature of using animals in a therapy setting. The primary goal of EAP is an advantageous outcome for the client. However, the incorporation of horses into the therapeutic environment raises concerns about animal wellbeing, client privacy, and healthcare equity.

Animal wellbeing. Ensuring the protection and welfare of the horse, with the possibility of improvement in wellbeing for the animal, is imperative. This must not only be assured during the therapy session, but also during times of inactivity and after the animal has retired from the therapy role. In essence, the hypothetical perspective of the animal must be considered in this treatment approach (Santori, 2011). A clear protocol must be in place that safeguards the care, wellbeing, and safety of the animal (Morrison, 2007). Screening for behavioral precautions in clients, including a history of animal abuse, and ceasing an intervention when the animal is disinterested or in danger is of utmost importance (Pendry et al., 2014; Vidrine et al., 2002; Morrison, 2007). Fortunately, within the animal-assisted therapy field, it is widely recognized that a fundamental premise of the work is a genuine relationship between the animal and the provider, as well as the manifestation of a genuine relationship between the animal and the client (Santori, 2011). However, if an animal is mistreated, governing bodies have the

authority to prosecute the offending parties (National District Attorneys Association, 2013).

Privacy. Traditional providers may also be concerned about protecting a client's privacy, and referring a client to an outdoor setting may be problematic. This is a concern that must be addressed with the individual client; however, it has been noted that a client approaching a stable may more easily be able to hide the fact that he or she is attending therapy. This may be especially appealing to adolescents who object to being labeled as a "patient." In addition, as with touch, the open environment, which may be a source of concern, can also be a catalyst for therapeutic breakthrough as the variety of locations in an EAP setting (i.e. enclosed stall, structured arena, open field) can provide symbolic meaning to the client (Bachi et al., 2011).

Equity. Research specific to EAP is less diverse, and there are specific vulnerable groups who are wholly underrepresented. These include people who are non-English speaking; older than 65 years of age; and/or a part of the lesbian, gay, bisexual, and transgender (LGBT) community.

Race and ethnicity. The racial and ethnic diversity of participants is ample in the overall literature for equine-assisted interventions, but is less abundant in the literature specific to EAP (Greenwald, 2001; Dell, 2008; Schultz et al., 2007). A fair number of studies did not disclose race in the population demographical data, and a select few were conducted with primarily Caucasian participants; however, this does not appear to reflect the overall demographics of EAP consumers (Trotter et al., 2008; Klontz et al., 2007; Meinersmann, Bradberry, & Roberts, 2008; Kern et al., 2011; McConnell, 2010).

Despite the limitations in the EAP research, a study conducted by Schultz, Remick-Barlow, and Robbins (2007) reported 49% of participants were from minority populations. In addition, a cross-sectional descriptive study with respondents from 45 states (excluding Alaska, Hawaii, Nebraska, North Dakota, and South Dakota) reported that the ethnicity of clientele served by equine-based therapy programs is approximately 65% Caucasian, 10% African-American, 10% Native American, 10% Native Hawaiian, 10% Hispanic, 5% Asian, and 5% of other ethnicity (McConnell, 2010). These percentages are representative of the minority-majority ratio of the United States, with the percentage of non-Hispanic White persons representing 63% of the population (United States Census Bureau, 2014). In addition, it has been qualitatively noted that greater successes occur in equine-based group therapies when the group is "relatively heterogenous in terms of specific diagnoses, ethnicity, and gender" (Vidrine et al., 2002).

Language. No studies indicated providing EAP to non-English-speaking persons. Additionally, not having a proficient grasp of the English language was noted as a criterion for exclusion (Pendry et al., 2014). This is disconcerting as 21% of people living in the United States do not speak English in their homes, and of these persons, 22% report they do not speak English well or at all. This is especially true for persons of Asian ancestry (Ryan, 2013).

This limitation in services is a significant concern because it excludes persons who are particularly vulnerable to psychosocial stressors and often have less access to mental health services. Recent data reveal that "older Asian-American women have the highest suicide rate of all women over age 65 in the United States," and suicide attempts by Hispanic females in 9^{th}-12^{th} grades are 70% higher than attempts by Caucasian

females of the same age group (Office of Minority Health, 2013). Bridging this gap is not an easy feat, but employing bilingual providers, encouraging providers to learn other languages, and/or employing translators in practice, could expand services to these populations.

Sexual orientation. No studies reported using EAP for persons with mental illness in the LGBT population, and one explicitly excluded this group due to limitations of the research instrument (Russell-Martin, 2006). However, the LGBT population has a higher prevalence of mental illness than that of the general public. This may be related to the experience of "minority stress," which is described as a hostile and stressful social environment caused by stigma, prejudice, and discrimination (Meyer, 2007). Though EAP has not been studied for persons in this community, it can be speculated that it would be an effective therapy due to the unbiased nature of the horse.

Age. In addition, though the therapy was indicated for children as young as three, there was not discussion about using EAP in the geriatric population. The oldest age mentioned in the literature under selection criteria was 65-years-old (Meinersmann et al., 2008). However, this does not mean older persons should be excluded from EAP. Health concerns may be more pronounced in this community and greater consideration of safety is indicated for the type of therapy provided (i.e. EAP that includes riding may be contraindicated for an elderly woman with osteoporosis). However, if EAP has psychological benefits for this population, it would be ethically unsound to withhold this type of treatment.

While cultural perspectives toward animals and individual physical health should be considered when providing EAP, future research efforts should ensure the inclusion of

these previously excluded or underrepresented groups. Expanding the availability of services to all who may benefit is imperative for providing equal opportunity and equity in care.

Safety. Patient safety regarding CAM therapies is still a priority provider concern, and therapies utilizing animals bring their own unique risks. A primary concern with horses is their large size, as many weigh a thousand pounds or more (Lentini & Knox, 2009). The substantiality of their presence is an essential part of their role in therapy; however, it can also place a client at risk of harm if the animal is or becomes unmanageable (Lentini & Knox; Selby, 2009). To mitigate this danger, horses are selected on the basis of their temperament and an equine specialist is present during sessions to ensure the safety of both the client(s) and the horse(s). However, the risk remains with even the most docile of horses, so extra caution is warranted for persons with certain conditions of cognitive disabilities (i.e. traumatic brain injury or dementia) who may unintentionally aggravate the animal, and possibly cause the horse to buck, kick, or otherwise place the client in danger (Morrison, 2007).

Another potential concern is zoonotic diseases. Horses are able to transmit different diseases to their human companions. This can occur through direct contact with the client or as the client participates in common equine-related activities, such as mucking stalls (Morrison, 2007). Possible infections include rabies, ringworm, and salmonellosis, as well as the lesser known diseases campylobacteriosis, cryptosporidiosis, and leptospirosis (King County, 2011). However, simple care for the animals, including standard veterinary care, as well as optimal hand hygiene by the client, both before and after interactions with the horse, greatly reduces the risk (Morrison, 2007, Ernst, 2013).

In addition, no evidence exists that infections have been transmitted from animals to humans in any significant numbers during animal-assisted therapy (Ernst, 2013).

Provider knowledge-deficit. Even when all other barriers have been diminished, a lack of knowledge regarding EAP in the general medical and mental health care community still stands as an affront to utilization of equine-based services, and understandably so. Providers not only need to be able to select appropriate clients for this type of therapy, but also need to know which type of modality is most suitable, and which providers are qualified to offer this specialized type of care. The majority of providers surveyed in the literature expressed motivation to expand their knowledge regarding non-traditional therapies, and those who provide EAP are the most qualified to offer this education (Flannery, Love, Pearce, Luan, & Elder, 2006; Wong et al., 2010; Sikand & Laken, 1998). In response, the EAP community should target educational efforts toward professionals who most frequently interact with clients likely to benefit from these services. This includes nurse practitioners, physicians, therapists, school counselors, and case managers (Bachi et al., 2011; Schultz, Remick-Barlow, & Robbins, 2006). Parole officers and those involved in the juvenile dependency and/or delinquency systems may also appreciate appropriate education.

DNP Project

The Knowledge Transfer Model, developed by Martha Driessnack, was utilized to determine overall needs regarding EAP implementation and develop the quality improvement project. The model has three key aspects: (1) awareness, which includes knowledge creation and knowledge exposure; (2) adoption, the intention to utilize and the actual utilization of knowledge; and (3) adaptation, at which point the knowledge is

regularly employed in practice and has the greatest impact on individual clients and the population as a whole. It is at this stage that further knowledge generation can occur, and the cycle can begin afresh.

As this student assessed the current state of EAP in the identified community, it became apparent that more work was necessary in the earlier stages of awareness and knowledge dissemination. There was a gap in the literature related to general understanding of the therapy in the medical and mental healthcare communities, as no data related to provider knowledge or perception of EAP could be found. For this reason, the project was aimed at generating this information.

Conducting the Project

To generate data related to provider knowledge regarding EAP, this student reviewed the literature and conversed with mental health specialists to identify common misconceptions related to EAP. Out of this exploration, this student developed a survey that asked questions specific to these fallacies. The survey was to be sent to medical and mental healthcare providers throughout the state of Oregon. The proposed project was vetted and approved by the Oregon Health & Science University institutional review board (IRB), an Oregon-based hospital's IRB, and the administration of a local clinic.

Setting

There was no specific setting for the site, as this was an email survey. The survey was sent to medical and mental healthcare providers in Oregon.

Participants

Medical and mental healthcare professionals in Oregon were asked to participate in an online survey. Types of providers included but were not limited to: medical doctors

(MDs), doctors of osteopathy (DOs), nurse practitioners (NPs), physician's assistants (PAs), psychologists, licensed professional counselors (LPCs), and licensed clinical social workers (LCSWs). According to Kaiser Family Foundation (2014), there are 10,890 physicians (MDs & Dos), 2548 nurse practitioners, and 1288 physician assistants throughout the state of Oregon. Data regarding the number of therapists, counselors, and social workers was unattainable.

Participants were contacted through a volunteer listserv for Oregon counselors, as well as through convenience sampling obtained through the student's clinical placement and current place of work. Approximately 650 providers were contacted. Participation was anonymous. The student did not know whether or not colleagues completed the survey, so collegial and work relationships were not impacted by participation or lack of participation by those known to the student.

Implementation

The survey was sent to the general listserv for counselors and to the personal email addresses for providers at the student's residency site and place of work. An EAGALA colleague added the student to a listserv for Oregon counselors, and email addresses were obtained from the administrative staff at a local clinic and through the internal server at an Oregon based hospital.

Approximately half of the email addresses were known, and the survey was emailed to all providers anonymously. To ensure anonymity, IP address and email address tracking was disabled prior to sending the survey, and the recruitment emails were sent using the blind carbon copy feature of the student's school and work email

accounts. No personal identifying information or personal health information was collected.

After the addresses were collected, the only form of contact regarding the study was via email. All participants were sent a request to complete a Survey Monkey questionnaire. Follow up emails were sent weekly for three weeks, with the last email stating that it would be the final notice. Once the survey was closed, participants were no longer contacted.

The Survey

The survey began with a brief introduction regarding the therapy and an explanation regarding the reason for the survey. Each participant was asked to indicate voluntary consent prior to initiating the survey. Without prior consent, the survey was inaccessible. This was written as follows:

> Equine-assisted psychotherapy is a type of therapy that uses horses to treat a variety of mental health conditions. This is an anonymous 9-question survey meant to assess provider knowledge and perception regarding this type of therapy. By understanding current perspectives, equine-assisted psychotherapy providers will be able to identify opportunities to enhance education regarding this lesser known treatment. At the end of the survey, you will receive an educational handout to save for your files. Thank you for choosing to complete this survey! By clicking "next" you indicate that you voluntarily agree to participate in this study.

The assessment consisted of six close-ended questions regarding common misconceptions of EAP and three demographic questions. The EAP questions were

formulated by misbeliefs expressed by those in the medical and mental healthcare field, as well as those demonstrated in the literature. The EAP questions were asked in a true/false format and written as follows:

1. EAP is a way for clients to gain confidence by riding horses. [False]
2. EAP uses the same psychological theories that are used in in-office settings. [True]
3. EAP is similar to pet therapies that utilize dogs or other animals. [False]
4. EAP is more for children and adolescents than adults. [False]
5. EAP will not be covered by most insurance companies. [False]
6. EAP must be conducted by a mental healthcare professional. [True]

In addition, the demographic questions were addressed using a close-ended multiple-choice format. The three questions that were assessed are as follows:

1. What is your profession?
    a. Physician (MD, DO, Psychiatrist)
    b. Non-Physician Clinician (i.e. NP, PA, ND)
    c. Mental Health Therapist (i.e. Psychologist, LPC, MFT, LCSW)
    d. Other, please explain:
2. How many years have you been in practice?
    a. 0-5 years
    b. 6-10 years
    c. 11-20 years
    d. >20 years
3. How often do you practice in a rural setting?
    a. Full time

b. Part time

c. I do not practice in a rural setting

d. Other (please specify)

At completion of the survey, providers received an electronic handout regarding "myths & facts" about EAP. The handout addressed each of the survey questions, and provided additional information about the therapy, as well as a reference list. Additionally, an automatic "Thank You" message was sent to participants who completed and submitted the survey.

Outcomes

The survey was sent to approximately 650 medical and mental health care providers in Oregon. Of these, 103 providers responded and 102 completed all of the questions. The results were compiled and released in aggregate form through SurveyMonkey to the student, who shared these with the faculty principal investigator and committee chair. The results were analyzed anonymously using SurveyMonkey tools. Descriptive statistics were displayed in chart form, comparing responses to EAP questions with participant demographics.

Overall results

The two most significant areas for potential education enhancement were related to the practice of EAP and insurance coverage. Seventy-five percent of participants reported that they believed EAP is a way for clients to gain confidence by riding horses. In the vast majority of EAP programs, clients do not ride horses, but rather interact with the horses on the ground. Additionally, the focus of all EAP sessions is therapy, not on developing horsemanship or horseback riding skills (EAGALA, 2014; PATH Intl., 2014).

Providing education and/or demonstrations about how EAP sessions are conducted can vastly reduce this common misconception of the therapy.

Additionally, 73% of all participants believed that insurance companies would not cover EAP. Except in the rare case where there is a stipulation against using horses in psychotherapy, equine-assisted psychotherapy can be billed under standard CPT therapy codes (EAGALA Community Network, 2013). This is because the therapy does not have its own theory, but utilizes proven clinical psychology methods, such as solution-based therapy and cognitive-behavioral therapy. For this reason, as long as the EAP provider is credentialed with the client's insurance company, clients can schedule for EAP the same as they would for traditional therapy. In addition, many programs are able to provide EAP for specific populations of clients through dedicated grant work (Morrison, 2007; Bachi, 2011).

Understanding the differences between EAP and other animal-assisted therapies also proved to be an area with the potential for enhanced education. Nearly two-thirds of providers (62%) believed EAP is similar to other pet-therapies. However, EAP is quite different from other animal-assisted therapies due to the nature of the horse. Horses are prey animals, which makes them highly attuned to their environment and sensitive to body language. Their survival is based on this awareness, so they respond directly to their surroundings, including the client's movements and body language. They are herd animals, so they often mirror the client's emotions and internal state. They are domesticated and social, which allows for a high amount of interaction with the client. Lastly, their large size permits the client to explore issues around vulnerability, power, and control (Bachi, 2011; Boyd, 2013).

In regard to the credentialing of EAP providers, the majority of participants answered correctly that qualified mental health professionals must conduct the sessions. However, just over one-third (37%) of respondents believed providers did not have to be qualified mental health providers. This misconception is evident in the literature as well, particularly as it relates to the menagerie of terminology used in the field and the subsequent confusion this creates (Kruger et al., 2004). To be considered equine-assisted psychotherapy, sessions must be conducted under a qualified mental healthcare professional who is under a supervisory board and working within his/her scope of practice (Kruger et al., 2004). The therapy must incorporate specific client objectives, a treatment plan, formal documentation, and measured progress. This is in contrast to equine-assisted activities, which take a more general approach, may not require a licensed mental health professional, and are aimed at skill building and education (Masini, 2010; Haubenhofer, Elings, Hassink, & Hine, 2010; Kruger et al., 2004; Marino, 2012).

Medical providers were more likely than mental health providers to falsely believe that EAP does not need to be conducted by a mental health professional. Approximately 60% of medical providers answered in this fashion, which is a significant trend, especially as it relates to potential utilization of this therapy. Rightfully, most providers will not refer a client to an intervention if they believe the person conducting the session is not qualified to do so. Interestingly, participants who identified as rural providers were also more likely to believe the fallacy. This may be due to limited resources in rural environments and the subsequent response of “doing everything” in these settings, or perhaps having greater exposure to the latter type of program (M. Driessnack, personal communication, April 2015).

The final two questions were more widely understood by healthcare providers. Providers generally understood that the psychological theories utilized in traditional settings are the same theories used in EAP. However, there was a significant difference between rural and non-rural providers in regard to this understanding. Those who did not identify as rural practitioners were more likely than their rural counterparts to answer incorrectly. Nearly 70% of non-rural practitioners believed the theories used in EAP are different from those used in traditional settings. For providers who are not familiar with a farm-based setting, the therapy may seem more foreign, and therefore more dissimilar to what takes place in traditional settings. Regarding for whom the therapy is effective, the vast majority believed the therapy is as much for adults as it is for children. This is accurate, and the knowledge may have been generated by the media's representation of EAP, especially as it has related to veterans (Fox News, 2011; Johnson, 2014).

Overall, the larger knowledge deficits tended to be in medical providers more than mental healthcare providers and those who had been in practice for more than 10 years rather than those newer to the field. Both of these findings are sensible, as those who perform therapy would realistically be exposed to more types of the work that they practice. Additionally, because EAP is a relatively young field, it's reasonable to believe those closer to academia would be more exposed to this newer treatment modality. Interestingly, those in practice from 6-10 years were the most knowledgeable about the therapy. However, results indicate that all providers—medical and mental healthcare providers, rural and non-rural providers, those early in their careers and those with a high amount of experience—could benefit from enhanced education regarding this type of therapy.

Limitations

This study had a small sample of providers with a limited response rate of 15%. Given this factor, the generalizability of the results is quite limited. The study did not include the whole sum of professionals who work with difficult-to-treat populations who could benefit from this treatment. For instance, parole officers and clergy were not recruited for participation. In addition, the study was limited to six possible misconceptions, though there is a large array of factors that may be misconstrued by those unfamiliar with the treatment. An open-ended format may have been more conducive to soliciting the precise misinformation that is prevalent in the population. Finally, the demographic data of the participants was pooled into gross categories, which may have swayed the overall outcomes.

Recommendations & Next Steps

This project was a small step forward in increasing awareness among healthcare professionals; however, more work is needed to improve provider uptake of the current knowledge base. This survey can be sent to a wider selection of providers, including Oregon-based hospitals and clinics not recruited in the current study. Recommended modifications to the current study include the following: (1) adding an “I’m not sure” option to the true/false format, (2) cataloguing providers whose practices bridge medical and mental health, such as psychiatrists and PMHNPs, in a separate category, (3) inquiring about overall rural health experience rather than limiting the question to current practice, (4) adding an open-ended section for provider perceptions, comments and/or questions, and (5) adding a pre-test/post-test component.

In addition to surveying providers, other options for increasing awareness include EAP demonstrations with media involvement, presentations to professional groups, and classes and/or workshops for continuing education units (CEUs). Using the findings of this study, this student gave an informal presentation to an Oregon-based organization for professional counselors, partook in a live-demonstration of the therapy on an Oregon-based news program, and helped lead an "open barn" demonstration that was open to the general public and involved a local newspaper. The primary findings from the study were shaped the educational components of the presentation. Additionally, preparing a curriculum to submit for CEU-approval is a project this student is projecting to complete in the upcoming year.

When awareness of the therapy has more deeply permeated the provider base, and the intention to recommend/utilize the therapy increases, the next step is assisting providers in adopting the option. As the EAP program options increase, developing a living document that contains a list of current programs, EAP provider specialties, and accepted insurance policies will facilitate the referral process. In addition, as grants are obtained to provide EAP to specific populations, healthcare providers who opt-in to an EAP listserv could be notified via email.

Lastly, as EAP becomes a regularly employed treatment option for clients, EAP providers will be documenting outcomes at the point of care. This generation of field-based knowledge has the potential for expanding the current research base, which can be disseminated to providers via EAP organization websites, peer-reviewed journals, and the methods previously discussed. Most importantly, it is at this point of care that the greatest

impact occurs, as clients who were difficult-to-treat in traditional settings make significant breakthroughs in the EAP arena.

Dissemination

The findings were presented to faculty and peers at the Oregon Health & Science University (OHSU) School of Nursing in a formal presentation. Additionally, the results were shared with members of the Oregon EAGALA Networking Group at the monthly meeting. Finally, the results were formulated into a report for submission to the EAGALA magazine.

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