

COUNSELOR EMPATHIC RESPONDING IN THE PRESENCE OF A THERAPY  
DOG

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**Abstract**

This study examined the difference between counselor empathic responding with and without a therapy dog in their counseling sessions was examined in a within-subjects design. Counseling consisted of animal-assisted therapy, play therapy, and other psychotherapeutic activities with elementary aged clients. Seven female school psychology graduate student clinicians were rated on their empathic responding using the Carkhuff (1969) Empathic Understanding in Interpersonal Processes Scale. A 2 (Dog Presence) X 4 (Empathy Level) analysis of variance was used to evaluate the difference between counselors' empathic responding. The hypothesis that the therapy dog would have a beneficial impact on the counselors' empathic responding was not supported by the results. The findings indicate that the therapist talks more when the dog is present, mainly due to an increase in Level 1, low empathic responses, and that higher level empathic responding did not vary between conditions as measured in utterances per minute. Further research is needed to determine how to incorporate an animal into therapy while maintaining the core facilitative condition of empathic understanding.

## **Chapter 1**

### **Introduction**

In the study and practice of psychotherapy, one of the most important and complicated questions to answer is what factors elicit a positive outcome for those seeking treatment. This question has been a focus of research for decades, and in the developing branch of animal-assisted therapy (AAT), it is crucial to establishing the credibility of this treatment. AAT is conducted by health or human service professionals and uses animals as a central part of a therapeutic treatment plan. The animal is used as a treatment tool within the broader framework of the practitioner's theoretical orientation. Potential clients, mental health insurers, AAT programs in hospitals and schools, and organizations providing funding for further research are among those interested in seeing what the value of AAT will be as the body of research grows. A previously unobserved area of AAT, the impact of therapy animals on counselors, may offer yet another path toward demonstrating the ways in which animals benefit the therapeutic process.

Empathy has for decades been considered one of the core interpersonal skills necessary for effective communication and rapport building in counseling, as well as a facilitating condition for growth and change (e.g., Bohart & Greenberg, 1997; Carkhuff & Berenson, 1967; Rogers, 1951). Empathic responding has been applied across many theoretical approaches to counseling and diverse client populations (Clark, 2007; Feller, 2003). Empathic responding by therapists is an important element of therapeutic interventions because it facilitates recognition of emotions and expression of empathy by clients. Animals used in therapy may also convey empathy to the client through their

body language. Fine (2010) noted that the “integration of an animal into therapy promoted a more nurturing and safer environment for clients” (p. 169).

Researchers in the field of AAT hypothesize that animals can also play a role in developing and eliciting empathy in clients (Fine, 2010; Olex, 2002). The means by which animals impact client empathy is unclear. Most of this research has focused on the client’s behavior (e.g., Schneider & Pilchak-Harley, 2006); however, another possibility is that the animal’s presence has an indirect effect on the client through a change in the counselor’s behavior. No research could be found examining the impact of conducting animal-assisted therapy on the counselor’s behavior, even behavior as fundamental to psychotherapy as empathic responding. The present study examined counselors’ empathic responding in conditions with and without an animal present, to attempt to shed light on this unique aspect of the role animals may play in therapy.

### **Animal-Assisted Therapy**

In the field of animal-assisted therapy, the use of animals to promote empathy in clients has been a popular topic of research (Ascione, 2004; Daly & Morton, 2003; Hergovich, Monshi, Semmler, & Zieglmayer, 2002; Olex, 2002). While there are correlations between empathic behavior and interactions with animals noted in much of the research, it is often unclear whether a person with naturally higher levels of empathy interacts more with an animal versus whether interacting with the animal improves empathy for humans.

One study examined the effect of a dog’s presence on participants’ perceptions of the counselors and willingness to self-disclose information to them. Findings indicated more satisfaction and willingness to disclose information in the condition with the dog

present (Schneider & Pilchak Harley, 2006). This study suggested that the presence of an animal changed the way clients perceived counselors. It may also be possible that a counselor seeing their client interact with the animal changes their impressions of the client, perhaps making it easier to empathize with them. More research is needed to determine whether the effects of an animal in the psychotherapy room influences counselors' behavior as well as that of clients. The results of another study (Allen, Blascovich, Tomaka, & Kelsey, 1991) on the autonomic stress response in women suggested that the participants might feel less anxiety about their performance in the presence of a nonevaluative therapy dog than in the presence of a friend. Halm (2008) found that the impact of animals on the hospital environment was not only positive for patients; it also improved staff attitudes toward the work place. The animals may help the staff to reduce stress and maintain an optimistic attitude which no doubt translates to better care for patients. These findings suggest that counselors may feel more at ease and therefore demonstrate more accurate perceptions and responses to the emotional states of their clients when accompanied by a therapy dog.

#### **Choice of animals in therapeutic settings.**

According to Granger and Kogan (2010), dogs are the most common animals used in therapeutic settings and have the longest documented history of use for this purpose. Their trainability and typically more social nature make them preferable to cats and other animals. However, there is also a significant amount of research on the use of horses and a variety of small animals for therapeutic gain. Therapists should consider the match between the animal's beneficial traits and the client's needs. Animals should also be screened for good health and temperament.

**Effects of AAT on Counselor Behavior**

A review of the literature has revealed anecdotal and qualitative evidence suggesting that a therapy animal may have a positive impact on the professionals working with them in addition to the benefits for clients. Pichot and Coulter (2007) and Dew (2000) provided personal accounts of the effect they believe their therapy dogs had on them as professionals. Blankley (2003) and Olex (2002) reported on qualitative studies including counselors' reports of the impact of therapy animals on handlers.

Pichot and Coulter (2007) reported that the positive impact their therapy dogs had on their handlers and other professionals in their place of work can actually improve the work environment and facilitate better treatment for clients. Sharing their experiences working with a therapy dog, the authors noted that the playful sincerity expressed toward the dog helped the handler to present a more open and relaxed attitude toward clients and coworkers. The presence of the dog led to more smiles, laughter, and initiations of social interactions from others, and the handler reported, "in response I was more genuine and relaxed around them as well" (p. 189). They also attributed improved communication, a stronger sense of community, opportunities to relieve stress, and increased positive energy in the workplace to the presence of the dog and the routine the handler had of visiting each office with the dog. The communication improved cooperation between programs and departments which translated to better services for clients. Finally, they commented that a therapy dog in the workplace "evokes curiosity, compassion, forgiveness, and a desire to reach out to others" (p. 203).

Dew (2000) described her work with Moses, a golden retriever, as comparable to that of a co-therapist. Moses communicated nonverbally to clients and counselor,

sometimes bringing client behaviors and emotions to the counselor's attention with his reactions to clients. He provided a comforting atmosphere which allowed the counselor to join with clients more quickly. "Moses is so in-the-moment that I stay conscious of the present and am excited to see what is next. He keeps me humble as well as fresh" (p. 202).

Blankley (2003) questioned mental health professionals who practiced AAT about the impact of animals in counseling. Among other factors, the impact of the animal on the counselor was examined through semiformal interview questions about the advantages and disadvantages of working with an animal. Of the three themes found, two were positive and one was negative. First, counselors viewed the animal as another tool for them to use. Second, they stated that the animal helped establish a unique working relationship with clients. The drawback was that working with an animal was more demanding in that the therapist had to work harder to attend to both the animal's needs and reactions, as well as those of the client. Other impressions were that animals in therapy increased spontaneity, insight, and modes of communication with clients.

Olex (2002) also conducted qualitative research on counselors' perceptions of the role animals play in therapy. Though she specifically targeted the development of client empathy, the data presented two of nine themes that reflect the impact of the animal on counselors. The animal was reported to help counselors decompress from challenging sessions and was considered a source of support. Similarly to the self-report from Dew (2000), therapists in this study also reported that the animal may pick up on emotions and behaviors in clients and signal the therapist to attend to what they might otherwise have overlooked. As expected based on the human-animal bond research presented earlier,

counselors in these studies seem to pick up on a noticeable change in their own behavior, including feeling more at ease and able to attend to the client's needs. However, dividing attention between the animal and the client presents the potential for overloading the counselor's attention which may be more of a risk for novice counselors.

More research is needed to substantiate claims of the above-mentioned studies. The impact of a therapy animal on the client and the counselor-client relationship will continue to be revealed through more rigorous investigation. In addition to this, the following question still needs to be asked. What impact does the therapy animal have on the counselor's behavior, and how does that indirectly contribute to the therapeutic outcome? Given the importance of empathic responding to most psychotherapeutic approaches and the evidence of animals impacting empathy in human companions and clients, the study of this behavior may be a good starting point for examining how therapy animals may bring out the best in counselors as well as clients. To assess the impact of the construct of empathic responding, it must first be defined so that it can be quantified and measured.

### **Empathy**

Webster's 3<sup>rd</sup> New International Dictionary (Grove et al., 2002) defines empathy in part as "the capacity for participation in or a vicarious experiencing of another's feelings, volitions, or ideas and sometimes another's movements to the point of executing bodily movements resembling his" (p. 742). Sympathy on the other hand is defined in part as "an affinity, association, or relationship between persons... wherein whatever affects one similarly affects the other" (p. 2317). The difference, therefore, is an understanding of another person's perception versus the sharing of two similar

perceptions. Sympathy is also considered as feeling sorry or concerned for another, rather than truly understanding the emotional response of another (Bohart & Greenberg, 1997).

### **Empathy in Psychotherapy**

Empathy in psychotherapy has been defined as consisting of different modes: experiential, communication, and observational. Respectively, these different modes refer to an attempt to understand the present inner experience of the individual, communicating this understanding, and attempting to understand the lifelong experiences of the individual in order to explain or interpret their experiences for the purpose of psychotherapy (Clark, 2007). While the construct of empathy is complex and abstract, it is a concept worth further investigation, as it has previously been linked to regulation of aggression, prosocial behavior, communication, social relationship building, and an organizing role in development and adjustment (Bohart & Greenberg, 1997).

Research on the common factors of successful counseling has identified empathy as one element of treatment that is likely to facilitate change. Rogers (1951) cited F.E. Fiedler's research on factors differentiating expert and nonexpert therapists from three different psychotherapy backgrounds. The study showed the most significant factors differentiating experts from nonexperts were "the therapist's ability to understand, to communicate with, and to maintain rapport with the client" (Rogers, 1951, p. 55), which is essentially empathy. Rogers also suggested that conveying empathy and warmth to clients might lead them to internalize this pattern of responding and result in them behaving with more warmth and empathy toward others. Carkhuff and Berenson (1967) concluded from previous research that certain core facilitative dimensions have the

greatest impact on positive client outcomes regardless of theoretical orientation or technique. These include counselor empathy, positive regard, genuineness, and concreteness. “For all rapport, the root of caring, stems from emotional attunement, from the capacity for empathy” (Goleman, 1995, p. 96).

Across theories, empathy can be applied in a variety of ways, including building the relationship using reflection, self-disclosure, assessments, and questioning. It can also be integrated throughout therapy with techniques such as confrontation, reframing, cognitive restructuring, and interpretation (Clark, 2007). The use of empathy seems to facilitate open communication and the breaking down of defense mechanisms in a way that makes the therapeutic setting a safe environment for self-exploration and personal growth.

### **Measuring Empathy in Psychotherapy**

Defining empathy in measurable terms is a task necessary to evaluate its role in psychotherapy, and to improve the training of counselors in this skill domain. While counselor empathy has been measured by a variety of client and/or counselor ratings, few researchers have developed objective observer-rated measures. Carkhuff’s Empathic Understanding in Interpersonal Processes Scale is an observer-rated measure which was typically used by two or more raters reviewing two- to four-minute samples of counselor and client interactions. They rated the counselor’s level of empathy based on their verbal responses (Bohart & Greenberg, 1997). Of the several observer-rated ordinal scales developed from the 1950s through the 1980s and discussed further in the literature review, Carkhuff’s (1969) empathic understanding scale was chosen for the present study because it was found to be widely cited and was likely to have been used in the training

of the subjects of the present study. Further details of the scale are discussed in the literature review.

### **The Current Study**

In addition to playing a direct role in facilitating communication, self-disclosure, and aiding the development of client empathy, AAT may have an indirect impact by influencing the counselor's behavior. As one of the core interpersonal skills incorporated into most theoretical orientations of counseling, empathic responding was chosen as the focus for rating counselor performance in the present study. If an animal's presence in the counseling setting can improve the counselor's performance for the better by increasing empathic responding, it would be reasonable to conclude that AAT has much to offer counselors and their clients. Clients would benefit from the sense of feeling understood and respected, as well as the modeling of appropriate empathic listening and responding skills. Studying this indirect aspect of the influence of animals in therapy may help to clarify our understanding of the benefits of AAT.

The present study examined counselors' empathic responding in conditions with and without a dog present, to attempt to shed light on this unique aspect of the role animals may play in therapy. The design included case studies of counselors working with a client, where a therapy dog was present for approximately half of the total time spent with the client. The counselors' empathic responding when the animal was present was compared to their empathic responding when the animal was not present. The advantage of such a design is that a number of variables can be controlled for, including client variables, animal variables, time, and setting. Other studies have found limitations, including difficulty interpreting results across different types of therapy, different

therapists, and different animals (Schneider & Pilchak-Harley, 2006). By following the same therapists with the same animal and client over time, some of these previous limitations have been eliminated. This approach allowed for a direct demonstration of a relationship between independent and dependent variables, which might be difficult in a between-groups design that must strive to meet certain assumptions for statistical interpretation.

It was hypothesized that the presence of the therapy animal would increase the likelihood that a counselor was more in tune with their client, and that counselor was therefore able to communicate with a higher degree of empathic accuracy.

## Chapter 2

### Literature Review

The following literature review examines the impact of animals on human behavior, with an emphasis on studies relating to how an animal may influence counselor responding in a therapeutic setting. Studies evaluating the influence of animals on human anxiety, performance, and empathy are reviewed. Defined below are animal-assisted activities, animal-assisted therapy, animal-assisted interventions, empathy, and the role of empathy in prominent theories of psychotherapy. Finally, the various methods of measuring counselor empathic responding through third party observations are discussed.

#### **Animal-Assisted Activities, Therapy, and Interventions Defined**

Pet Partners (formerly the Delta Society) is a human services organization which promotes health and well-being through positive interactions with animals. It is a national organization which provides education, certification, and direct services in the use of animals for therapeutic purposes. Their definitions of animal-assisted activities (AAA) and animal-assisted therapy (AAT) are among the most widely cited and are as follows:

Animal-assisted activities provide opportunities for motivational, educational and/or recreational benefits to enhance quality of life. While more informal in nature, these activities are delivered by a specially trained professional, paraprofessional and/or volunteer, in partnership with an animal that meets specific criteria for suitability. (Pet Partners, Terminology, n.d.)

Animal-assisted therapy is a goal oriented, planned, structured, and documented therapeutic intervention directed by health and human service providers as part of

their profession. A wide variety of disciplines may incorporate AAT. Possible practitioners could include physicians, occupational therapists, physical therapists, certified therapeutic recreation specialists, nurses, social workers, speech therapists, or mental health professionals. (Pet Partners, Terminology, n.d.)

In defining the research base used for his comprehensive book *Animal-Assisted Therapy*, Fine (2010) noted how the terminology has continued to evolve since his first publication and that currently there are many terms for the same phenomenon and even more definitions. Fine incorporated studies which do not meet the criteria for AAT but did use animals to attempt to generate positive change in peoples' lives due to a lack of studies that fit the AAT criteria. He called the broader group of research *animal-assisted interventions* and defines this as “any intervention that intentionally includes or incorporates animals as part of a therapeutic or ameliorative process or milieu” (p. 36). In the following review of the literature, studies which do not meet the Pet Partners criteria for AAT will be referred to as animal-assisted interventions (AAI).

### **Human-Animal Bond Research**

AAT, AAA, and AAI activities are based at least in part on the theory that animals in and of themselves can have positive influence on people. Physiological studies have found a connection between the presence of animals in the lives of humans and improvements in our health and well-being. According to Beck and Katcher (2003), two theories have attempted to explain the positive influence of animals on people – the biophilia hypothesis and the social support theory. These theories are different, but compatible, and together further our understanding of the human-animal bond.

The biophilia hypothesis is derived from evolutionary theory and was first proposed by the biologist E. O. Wilson (Kellert & Wilson, 1993; Wilson, 1984). The hypothesis suggests that humans have evolved from those ancestors who were best able to attend to animals and the surrounding environment. Ancestors with heightened awareness of their surroundings were likely to be successful hunters and gatherers, and able to avoid danger by reading the warning signs in the environment. Through selection of the fittest, human brains became biologically predisposed to a heightened attunement to animals and other environmental stimuli (Beck & Katcher, 2003). Melson and Fine (2010) noted that a heightened attunement does not imply love or a compassionate response to living things, only an interest due to animals' ability to benefit human survival.

With animal behavior serving as a cue for danger or safety, "friendly, calm animals are likely to have a calming effect upon human mood, while agitated, aggressive animals are likely to have the opposite effect" (Melson & Fine, 2010, p. 237). A number of studies have found a calming effect of an animal for humans in stressful situations (e.g., Beck & Katcher, 1996; Friedmann, Katcher, Thomas, Lynch, & Messent, 1983; Friedmann & Tsai; 2006; Katcher, Segal, & Beck, 1984; Nagengast, Baun, Megel, & Leibowitz, 1997; Wilson, 1987, 1991).

In one study, Katcher et al. (1984) examined the effects of hypnosis and contemplating visual stimuli on patients' anxiety and discomfort while undergoing dental surgery. Thirty-four patients between 21 and 60 years of age were placed in one of five groups: aquarium contemplation, poster contemplation (e.g., a picture of a waterfall), aquarium contemplation with hypnosis, poster contemplation with hypnosis, and a no-

treatment control group. Patients were rated on subjective and objective measures of anxiety and behavioral compliance, as well as heart rate and blood pressure. The study showed that contemplation of an aquarium had the greatest reduction of anxiety affecting both patients' subjective experience and objective behaviors. Furthermore, the researchers found that the addition of hypnotic relaxation did not increase the effectiveness of aquarium contemplation, making aquarium contemplation both an effective and practical intervention for implementation in a clinical setting. It was suggested that the complex moving stimuli provided by the fish was superior to static objects in producing relaxation.

In a more recent example of the biophilia hypothesis, Nagengast et al. (1997) studied the effect of an animal's presence on the physiological arousal and behavioral distress of healthy children, ages three to six, during a physical exam. A beagle, unfamiliar to the children, was used during one of two identical physical exams performed on each child. While some children had the dog present during the first exam, and some during the second, the results showed that overall the dog-present condition resulted in a significant decrease in mean arterial and systolic blood pressure, heart rate, and scores on the Observation Scale of Behavioral Distress.

It is important to note that while research has focused primarily on companion animals (animals which are pets, or were familiar to the subjects prior to the experiment), the biophilia hypothesis suggests that the mere presence of living matter including plants and animals, and activities such as hunting and farming, may have benefits for humans as well (Beck & Katcher, 2003). In the counseling setting, this could translate to having a plant, a fish tank, or an actual therapy animal in the environment. The theory suggests

that it is not necessary for the client or counselor to have established a relationship with the animal for it to have a calming effect on the people in that environment. In both children and adults, the physiological and behavioral indicators of anxiety have been noticeably reduced by the presence of a calm animal. Supporting the biophilia hypothesis, people in stressful situations may take cues from the calm animal that they are safe and can relax, and the animal need not be a family pet or familiar source of social interaction.

The social support theory is another way in which data about the effects of animals on human behavior can be conceptualized. This theory emphasizes the health benefits of social support, including material and emotional supports provided from a network of individuals, groups, and organizations (Melson & Fine, 2010). This network may include individual human and animal companions such as a spouse, friend, or family pet, as well as larger systems like religious communities and government agencies. According to Cohen and Wills (1985), these types of social support help to reduce stress, as well as the harmful physiological and behavioral results of stress, by providing a variety of supports, such as esteem, information, resources, and social companionship. Cohen and Wills describe esteem as the emotional support of knowing you are accepted despite your shortcomings, and define social companionship as spending leisure time with others, fulfilling the need for affiliation, taking our mind off our problems, and increasing positive emotions. The most logical areas of social support where an animal may have some benefit are the esteem support and social companionship categories. A number of researchers have suggested the increased social support of an animal companion can buffer us from the negative effects of stress (e.g. Allen et al., 1991;

Covert, Whiren, Keith, & Nelson 1985; Friedmann, Katcher, Lynch, & Thomas, 1980; Halm, 2008; McNicholas & Collins, 2001; Nebbe, 1991; Rost & Hartmann, 1994; Siegel, 1990).

Allen et al. (1991) examined the difference between human friends and pet dogs on reducing stress in women undergoing an experimental stress task involving mathematical calculations. Forty-five female dog owners, ages 27 to 55, completed two subtraction tasks in a laboratory and then two tasks in their homes. The home conditions included either a pet dog, a close human friend, or neither dog nor friend. Stress response was measured by skin conductance, systolic and diastolic blood pressure, and pulse rate. While all three groups responded similarly in the laboratory condition, stress response was significantly lower for pet owners on all measures during home testing. In addition, the presence of a close human friend increased stress rather than reducing it, possibly due to embarrassment or evaluation anxiety. The researchers hypothesized that “the presence of pet dogs during the performance of the stressful task provided the kind of nonevaluative social support that is critical to buffering physiological responses to acute stress” (p. 587). While the subjects in the control and pet present groups were consistent in their accuracy of responding, the presence of a friend decreased accuracy on the tasks.

A compilation of studies on AAI in hospital settings was conducted by Halm (2008). Halm alluded to both the effects of the biophilia hypothesis, by noting the induced relaxation from the attachment bonds between people and animals, as well as the social support theory. Patients experienced positive social support such as “bridging communication, providing company late at night, connecting with and touching the outside world... AAT not only normalized the hospital environment, but humanized the

ICU environment” (p. 375). In addition, the staff reported positive influences of the animals in the hospital environment, including making the “...work environment happier and more interesting, with no negative impact on space and work flow” (p. 375). While the focus of most previous research in the area of the human-animal bond has been on individuals or patients, these results allow for the prediction that the animal’s presence may also reduce stress in the examiner, practitioner, counselor, or other professional. This may be especially effective for those working under stressful conditions, such as professions where employee burnout is a concern.

Taken together, the biophilia hypothesis and the social support theory broaden our understanding of the possible benefits animals have to offer humans. However, these theories also broaden the spectrum of possible outcomes. Variation in genetic predisposition to attend to animals in the environment, past learning experiences with animals, and the degree of emotional attachment to the animal in a therapeutic setting may all influence the effectiveness of the therapy animal on human behavior and well-being.

### **Animals and Empathic Development**

In recent years, the interest in the role of animals in human development has increased and become an area of research which helps to lay the theoretical groundwork for AAT. More specifically, the following studies illustrate ways in which animals may play a role in the development of empathy, as well as moral and social development. Some examine the impact of pet ownership (Daly & Morton, 2009; Wood, 2011), and others look at the less intensive role of animal visitation programs or classroom pets (Ascione, 1992; Conniff et al., 2005; Daly & Suggs, 2010; Hergovich et al., 2002).

However, all highlight changes in human behavior, thoughts, or feelings due to the animals' presence and interactions.

Wood (2011) suggested that because companion animals facilitate communication, there is a connection between the development of empathy in the formative years of childhood and pet ownership. Pets, she said, can provide a common bond among children of different backgrounds and may be a useful tool for teaching communication and awareness of another's perspective. "A companion animal gives a child practice in relating to someone different from him- or herself, gives the child an opportunity to show empathy, and teaches the child how to accommodate the needs of another" (p. 30).

Daly and Morton (2009) examined the relationship between pet ownership and human directed empathy in individuals who owned pets in childhood and/or adulthood. Empathy was measured by the Empathy Quotient (EQ), a self-report measure, which identifies three factors of empathy: cognitive, emotional reactivity, and social skills. They also measured empathy with the Interpersonal Reactivity Index (IRI) which is also a self-report measure that identifies four domains: identification with fictional characters, the ability to take another's perspective, the ability to feel compassion for others, and personal distress as a result of witnessing harm done to others. Participants' attitude to animals was also measured. Adults who had owned dogs as children scored higher on the EQ-Social Skills scale and lower on the IRI-Personal Distress scale than those who owned cats only or neither cats nor dogs. For adult participants who were currently pet owners, those who owned dogs also scored lower on personal distress than those who owned neither dogs nor cats. The dog-only group also scored higher on social skills than

the cats-only and the neither cats nor dogs groups. The low levels of personal distress were suggested to mean that dog ownership may play a role in the owner's resilience to stress, leading to improved mental health. The social skills measured were described generally as the skills involved in producing unprompted responses that demonstrates social understanding. The social skills component of the EQ scales are the most relevant to the present study since they can be observed by a third party. The results of Daly and Morton's study suggest that a dog may have a positive impact on a counselor's ability to communicate empathy to their clients. However, their study deals with pet ownership, not AAT, and does not give any indication of the length or quality of the dog-owner relationship necessary to achieve a noticeable difference in social skills. It was also noted that people with high levels of empathy may be more likely to choose dogs as pets and the same may be true of counselors who are drawn to AAT.

Conniff et al. (2005) examined the effects of a one-hour per week, eight-week long animal-assisted activity (AAA) program on the emotional state and behavior of adjudicated teenage girls in a New York state residential facility. Their emotional state and behaviors were measured by the Youth Self-Report, Resident Behavior Assessment, and a qualitative survey. The quantitative measures showed no significant benefit, but qualitatively most participants enjoyed the AAA program. One limitation of the study was that it was partially based on self-reports and the youth involved were aware of the purpose of the study. Some participants admitted to lying because they worried the results would affect their participation in the program even though they were told otherwise. Additional limitations were the sample size, which was restricted by difficulty obtaining parental consent, dropout rates, the fact that the AAA program was infrequent

and short in length, and the lack of consistency of volunteers who brought the animals and socialized with the participants during the program.

Daly and Suggs (2010) surveyed teachers on the use of pets in the classroom. They collected quantitative and qualitative data with a questionnaire on a self-selected sample of teachers in Ontario, Canada and the results were largely positive. Teachers provided anecdotal evidence for the use of classroom pets to increase social skills, language, academics, and empathy. More than half of the teachers reported using formal humane education programs, which are aimed at fostering positive attitudes toward animals and respectful treatment of them. Many programs make the assumption that humane education fosters compassion and empathic treatment of human and nonhuman animals alike. While many teachers used classroom pets to teach these programs, they also incorporated other animals into the curriculum with field trips and nonliving animals in pictures and stories. The authors' findings support humane education programs and the use of animals in classrooms as a way to foster social and moral development in children.

Ascione (1992) conducted an experiment to study the effect of a humane education program on children's attitudes about the humane treatment of animals and its effect on human-directed empathy. A 40-hour, year-long humane education program was conducted by classroom teachers and included 16 control classes and 16 experimental classes of first, second, fourth, and fifth graders. Students were measured with a pre- and post-test of their attitudes toward the humane treatment of animals and empathy toward humans. Fourth graders in the experimental group showed a significant improvement in attitudes toward animals and empathy toward humans. First graders in the experimental

group showed some qualitative improvement in attitude toward animals but not a significant difference from the control group. A ceiling effect on the primary empathy measure may have prevented the identification of a treatment effect for human empathy in the first and second grade groups. Fifth graders showed a significant treatment effect for empathy toward humans but not attitude toward animals. Additionally, there was a significant positive correlation between primary and intermediate measures of attitude toward animals and measures of empathy toward humans, suggesting an important link between animals in the lives of children and moral development.

Hergovich et al. (2002) examined two classrooms of mostly immigrant children in Viennese schools. The researchers examined the effect of a dog's presence on student behavior. One classroom had a dog present for three months and the other classroom was used as a control group. They found that the dog-present group showed improved "segregation of self/nonsself, which is the foundation of sensitivity towards the needs and moods of other people" (p. 37). Another finding was the increase in "field independence" which was defined as "learning to pay attention to the needs of others (living beings) and their assuming responsibility for their well-being" (p. 41). They also found increased empathy with animals, social integration, and decreased aggression. The study, however, did not take into account the influence of the teachers on these variables and lacked a randomization of teacher and class assignments. In general, the results suggest a number of positive effects of a dog in the classroom, but the results may have been more significant for an immigrant population where the students had both language and transition barriers to overcome.

## **The Use of Animals in Therapeutic Settings to Promote Client Empathy and Related Behaviors**

Mental health counselors may choose to use animals to achieve many goals in psychotherapy, including improving socialization and communication, mood, memory, self-esteem, cooperation, attention and concentration, emotional expression, and reducing anxiety, grief, and isolation (Chandler, 2001). AAT has also been noted to improve client empathy (Burgon, 2011; Ewing, MacDonald, Taylor, & Bowers, 2007; Olex, 2002), and related social behaviors such as eye contact, communication skills, and initiation of interactions with other people (Kogan, Granger, Fitchett, Helmer, & Young, 1999; Limond, Bradshaw, & Cormack, 1997; Prothmann, Bienert, & Ettrich, 2006; Redefer & Goodman, 1989).

Olex (2002) conducted a dissertation on how the human-animal connection is used to facilitate the therapeutic process and specifically how animals are used to strengthen client empathy. Qualitative data was analyzed from interviews with nine clinicians using animals in therapy. Nine themes were highlighted, of which several related to the benefit of using animals to build the rapport with clients. One theme suggested that animals are more perceptive of the emotional climate of the session and behavioral changes in the client and may provide signals that draw the counselor's attention to these subtleties. She also found that counselors believed the animal helped clients trust themselves, trust others, and evaluate their own emotional experiences more fully. The animal is thought to respond to the client's behaviors with a physical closeness or withdrawal which provides immediate feedback to the client and helps them to understand their role in relationships.

Ewing et al. (2007) studied a range of perceptions, emotions, and learning in youth with severe emotional disorders who participated in an equine-facilitated learning program. Researchers did not find a significant change in interpersonal empathy measured by Davis' Empathy Questionnaire. Qualitatively, however, they observed empathic feelings and understanding in letters participants wrote to a volunteer whose horse died during the course of treatment. Burgon (2011) conducted a qualitative study of the effects of equine-facilitated learning therapy on seven adolescents in a foster care program. The subjects met every week or every other week for several hours at a barn and spent time caring for the horses, riding without a saddle, and directing them without a lead to learn how their body language could be used to elicit responses from the animal. A theme of the benefits of the program was that empathic development was considered to be facilitated by the building of relationships with the horses. Subjects treated the animals as confidants, openly expressed affection towards them by touching and talking softly to them, and empathized with new horses who were displaying signs of stress or anxiety.

#### **The use of animals to promote behaviors related to empathy.**

Several studies highlighted the impact of animals on eye contact, initiation of social interactions, and social skills. Since these behaviors are similar to behaviors necessary for empathic understanding and communication, they should also be considered to support the hypothesis that animals can be used to promote empathic behavior in humans. Kogan et al. (1999) studied the effect of AAT on the behavior of two male children, who were 11 and 12 years old. Participant A's therapeutic goals were to increase social skills and concentration. Participant B's goals were to increase social

skills, age-appropriate behaviors, and a sense of personal control. They attended weekly sessions of AAT for a minimum of 45 minutes each. Participant A attended 11 sessions and Participant B attended 14 sessions. The boys were instructed in how to train and work with the dog and also prepared presentations to give to their classmates on training the dog. They learned how “voice tone, eye contact, patience, memory, usage of positive reinforcement, and concentration were all instrumental in the dog’s correct responses” (p. 111). Teachers rated the two students on attention, hyperactivity, social skills, and oppositional behaviors, and an educational professional observed videotaped sessions and measured changes in voice quality and eye contact. The researchers also tracked the students’ Individualized Education Plans and interviewed the child, family, and educational professionals. Both children showed positive changes in voice from a quiet and uncertain tone to a firm and confident tone, and improved eye contact. Participant A showed growth in social skills and concentration. Participant B showed improved sense of control, age-appropriate behaviors, and peer relations.

Similarly, Redefer and Goodman (1989) studied AAT with children with autism and observed increased social interactions and decreased isolation. They found that when a counselor applied specific AAT strategies, such as encouraging interaction with the animal by touching or petting it, and then initiated games such as throwing a ball, feeding, or grooming the animal, the directive approach helped to teach turn taking, communication, and other socially appropriate behaviors.

Limond et al. (1997) observed changes in eight children with Down’s syndrome who interacted with a therapy dog. They compared differences between time spent with an imitation dog and a real dog. The children spent seven minutes with each once a week

for six weeks. In the real dog group, more sustained focus and interactions with the dog and with the adult present were noted. The sessions, however, were not therapy sessions and were guided by the therapy-dog handler who encouraged certain activities. Sessions were video recorded to allow for a broad exploration of possible behavioral changes. The types of behaviors measured included looking, responding to an adult, and initiating interactions verbally and nonverbally. The children spent significantly more time looking at the real dog, attended more to the adult, and gave more nonverbal responses to suggestions in the real dog condition. The children were also noted to be more focused on the real dog and were less distracted by other objects and noises during the real dog sessions. Initiations and verbal responses were similar across conditions. Although empathy was not explicitly measured in these studies, skills learned relating to how to interact with the animal could also play a role in empathic behavior toward humans. Those skills included attending to the animal and responding with appropriate voice and body language to elicit the desired responses. These skills would help with person-to-person communication as well. It is possible that the broader area of social skills measured in these studies may have included aspects of empathy towards peers and adults.

Along the same lines, Prothmann et al. (2006) researched the effect of therapy dogs on state of mind in adolescents. One hundred participants, ages 11 to 20, in a psychiatric inpatient treatment facility participated in the study, with 61 in the treatment group and 39 in the control group. The treatment sessions involved nondirected free play for 30 minutes with a therapy dog and a handler. A rating scale was used to measure changes in state of mind over time. It was administered before and after each treatment

session (five sessions total), and before and after the single session for the control group. It measured four domains, including vitality, intraemotional balance, social extroversion, and alertness. There was a significant increase in scores in the treatment group across domains. “That is, the presence of a dog increased to a large extent the alertness and the attention of the child, caused more openness and desire for social contact and exchange, promoted the perception of healthy and vital factors, and enabled the child to become psychologically more well balanced” (p. 275). Those with the lowest pre-session scores benefited the most from the sessions. The increase in attention and concentration were considered prerequisites for higher cognitive processing, which may include empathic attunement to the animal or humans. The authors hypothesized that these positive changes are related to the atmosphere of “warmth, acceptance and empathy” (p. 275) which the therapy dog brings to the mental health setting.

### **Empathy**

Although empathy was discussed previously, the following will more clearly define it. According to the *New Encyclopædia Britannica* (Empathy, 2003), empathy is a fairly new term in the English language, becoming prevalent in the early 20<sup>th</sup> century. It is derived from the German term *einfihlung* (p. 478) and appears to have been used first in an aesthetic sense, such as feeling connected to a piece of artwork or an actor putting him or herself in the mindset of the character. Barrett-Lennard (1981) stated that the origin goes even further back:

The early Greeks coined the word *empathia*, evidently meaning affection and also passion, with a quality of suffering. The *em* means “in” or “into,” and there is the idea at least of going into a strong feeling-connection with another. The

Latin equivalent was largely borrowed from the Greek. *Pathos* is from Latin, and as the modern suffix *pathy*, it can mean feeling-perception. (p. 91)

The *Oxford Companion to the Mind* (Empathy, 1987) defines empathy as “feelings of ‘belonging to’, associating ourselves with, or ‘being carried along’ with something” (pp. 220-221). The German philosopher and psychologist Theodore Lipps is credited with the application of empathy to a theory of aesthetics which states that “aesthetic pleasure is an enjoyment of our own activity in an object” (p. 221), and the term was later applied especially to architecture. The following example is given:

It has been suggested that when we look at the columns of buildings, such as Greek temples, we identify ourselves with the columns: if they are very thin, we feel uncomfortable as though they, like us, must be inadequate to take the weight they support; and if they are very fat, we feel uncomfortable as some people do when large and clumsy. (pp. 220-221)

### **Definitions and Roles of Empathy in Psychotherapy**

Barrett-Lennard (1981) credits E. B. Titchener with introducing the English equivalent of *Einfühlung* and advancing its use in both languages at the beginning of the 20<sup>th</sup> century. Following Titchener, Alfred Adler described his concept of social feeling and interest as including an awareness of the experience of another by putting oneself in the place of the other and showing a genuine interest in the other.

Empathy has been applied to the counseling technique and is an important part of the theory of counseling put forth by the American psychologist Carl Rogers in the 1950s (Empathy, 2003). Since then, it has become a common term in the field of psychology. Perhaps partly because of its roots in aesthetics, empathy seems to have a more prevalent

role in theories of psychology that emphasize the relationship between counselor and client, as though counseling is an art form in itself.

Most psychotherapies include some element of empathic understanding within their therapeutic framework. According to Elliott, Bohart, Watson, and Greenberg (2011), empathy is most prominent in client-centered therapy and psychoanalysis where an emphasis is placed on understanding the client's perspective. Clark (2007) identifies the role of empathy in contemporary psychotherapies slightly differently. He breaks them down into three categories: a significant role, a prominent role, and a recognizable role. Significant aspects of empathy are seen in client-centered therapy and self-psychology. Prominent aspects of empathy are seen in individual, existential, cognitive-behavioral, and psychoanalytic therapy, and recognizable aspects of empathy are seen in rational emotive behavior therapy, transactional analysis, solution-focused brief therapy, gestalt, constructivist, feminist, and family systems therapy.

#### **Empathy in play therapy.**

According to Landreth (2012), the therapeutic use of play began to emerge in the early twentieth century. Sigmund Freud's work with *Little Hans* was the first published case in 1909. Hermine Hug-Hellmuth, Anna Freud, and Melanie Klein were among the other pioneers in the development of play therapy. Though a psychoanalytic orientation was the first to be adapted to play therapy, many other orientations have branched out to include a type of play therapy for children including Adlerian, Jungian, child-centered, gestalt, relationship, cognitive-behavioral, child developmental, ecosystems, family, and filial play therapies (Carmichael, 2006). The role of empathic responding in play therapy varies with the theoretical orientation that is used by the counselor. The emphasis on

counselor empathic responding would be expected to be strongest in a client-centered approach, however, it would be present in most orientations to varying degrees, as described below.

**Empathy in client-centered psychotherapy.**

Carl Rogers defined empathy as “the therapist’s sensitive ability and willingness to understand the client’s thoughts, feelings, and struggles from the client’s point of view” (Rogers, 1980, p. 85). According to Rogers (1951), the counselor’s role in a client-centered approach was:

...to perceive the world as the client sees it, to perceive the client himself as he is seen by himself, to lay aside all perceptions from the external frame of reference while doing so, and to communicate something of this empathic understanding to the client. (p. 29)

Empathic responding, including reflecting the client’s feelings and demonstrating a developing awareness of the client, was considered one of several core facilitative dimensions of what Rogers called client-centered counseling. Rogers considered it a facilitator of client self-exploration that in turn would lead to successful treatment outcomes (Miller, 1989). Expanding upon this process of empathic communication, Carkhuff and Berenson (1967) explained:

The therapist’s ability to communicate at high levels of empathic understanding appears to involve the therapist’s ability to allow himself to experience or merge in the experience of the client, reflect upon this experience while suspending his own judgments, tolerating his own anxiety, and communicating this understanding to the client. (p. 27)

Barrett-Lennard (1981) noted that Rogers further refined the concept of empathy in psychotherapy by emphasizing a significant distinction between a sympathetic identification with another person involving a direct experiencing of the same emotions, and an empathic identification. The latter involves accurately understanding the experience, thoughts, and emotions of another person while maintaining a separateness or “as if” quality in the interaction (p. 92). Elliott et al. (2011) noted that sympathy was harshly contrasted with empathy by Rogers and others, and that in “affective neuroscience terms, this means that therapists in these traditions have often emphasized conscious perspective-taking processes over the more automatic, bodily based emotional simulation processes” (pp. 43-44). In other words, empathy was viewed as a conscious cognitive task rather than a reflexive emotional reaction.

Landreth (2012) referred to empathy in child-centered play therapy as “sensitive understanding” (p. 70). It was an active process of engaging with the child mentally and emotionally in order to better understand the child’s perceptions and way of experiencing the world. He described the therapist’s role as:

The attitude of the therapist is to sense as deeply as possible the experiencing of the child in the moment and to accept as fully as possible the emerging intuitive empathic response within herself as being sufficient for the moment. Thus, the relationship with the child is a continual prizing of the child’s uniqueness and an empathic experiencing of the moment-by-moment living out of the child’s world at a pace of unfolding determined by the inner direction of the emerging child. (p. 73)

### **Empathy in psychoanalysis.**

According to Clark (2007), in psychoanalytic theory, the role of empathy was present to a lesser extent than in client-centered psychotherapy. According to Bohart and Greenberg (1997), classical psychoanalysis used empathy as a way to identify and interpret the unconscious mind of the client. Defense mechanisms and the relation of past experiences to current functioning could not be understood without the use of accurate empathy. However, creating a warm empathic environment where empathy is expressed by the counselor as an emotional reaction to the client was considered countertransference as opposed to a corrective emotional experience for the client.

Heinz Kohut developed a branch of psychoanalysis known as self-psychology in which empathy had a more influential role. He believed that the therapist needed to vicariously experience the client's world to facilitate insight, and that the expression of empathy made interpretations more palatable to the client (Bohart & Greenberg, 1997). Later, he also concluded that the client's experience of feeling understood as a result of accurate empathic responding helps him/her to let down his/her guard and communicate more openly. In a transcript of his 1981 speech given days before his death, Kohut explained his final thoughts on empathy. He stated that empathy, along with introspection, are "informers of appropriate action" (2010, p. 125). However, it is not enough to know the client or to confirm that understanding with him. Moving from confirmation to interpretation was a necessary move from a lower form of empathy to a higher form.

A good analyst reconstructs the childhood past in the dynamics of the current transference with warmth, with understanding for the intensity of the feelings, and with the fine understanding of the various secondary conflicts that intervene as far

as the expression of these [childhood wishes and needs] are concerned. (Kohut, 2010, p. 128)

### **Empathy in cognitive and behavioral psychotherapies.**

The importance of empathy in cognitive and behavioral theories varies somewhat. It appeared to be viewed as a catalyst for engaging the client in the therapeutic work but not as a sufficient condition for generating change.

However, Burns and Nolen-Hoeksema (1992) conducted a study of 185 patients with depression receiving CBT and statistically controlled for the severity of depression, homework completion, and many other factors to determine the role of empathy in treatment outcomes. Their findings suggested that empathy in the therapeutic relationship had a direct impact on improvement that goes beyond the facilitation of homework completion.

According to Carmichael (2006), the role of the cognitive-behavioral play therapist was more directive and structured than child-centered approaches. However, the development of a relationship that is safe and predictable was still a necessary component of the therapeutic process. “As with other types of play therapy, rapport building is essential for the child to feel trust for the therapist to provide effective interventions. The therapist works to make the child feel he or she is in a safe, secure environment to explore and express the child’s behaviors and cognitions” (p. 153).

### **The Role of Empathy in Facilitating Positive Therapeutic Outcomes**

Many researchers have continued to be supportive of the idea that general factors of the therapeutic relationship, such as Rogers’ core facilitative dimensions, have more influence on outcome than factors specific to different treatment techniques (i.e., Angus

& Kagan, 2009; Burns & Nolen-Hoeksema, 1992; Elliott et al., 2011). Greenberg, Watson, Elliot and Bohart (2001) summarized the role of empathy in therapeutic outcome as a product of four mediating factors. “Three of these are the processes of empathy as a relationship condition, as a corrective emotional experience, and as a cognitive-affective processing condition. The fourth factor has to do with the role of the client as an affective self-healer” (p. 382). Essentially, empathy helps to build a strong working relationship between client and counselor, it helps clients learn that they are deserving of a relationship where feelings and behaviors can be openly communicated and respected, it helps clients process their feelings and behaviors, and it creates an environment where the client’s self-healing capacity can be fully realized (Greenberg et al., 2001). Bohart and Greenberg (1997) reviewed research on empathy and outcome since the 1970s and found the correlation between empathy and therapeutic change was “positive but weaker than originally thought” (p. 18). They stressed that the client’s perception of empathic attunement is most closely tied to positive outcomes.

### **Measuring Empathy in Psychotherapy**

Defining empathy in measurable terms is a task necessary, not only to evaluate its role in psychotherapy, but also to improve the training of counselors and others in helping fields. New methods of defining and measuring empathy were steadily explored in the psychotherapy literature following Roger’s work in the 1940s until approximately 1975. Concerns raised through rigorous validity and reliability studies led to doubts about the ability to concretely define and measure empathy. Research slowed in the area of developing a measurable empathy construct, and only since the mid-1990s has research in this area begun to pick up momentum again (Elliott et al., 2011). As a result,

there are a number of definitions, theories, and measures of empathy without a clearly superior method having been identified.

General empathy scales have been developed to measure a person's ability to empathize with the experiences of others. These measures focus on the development of empathy in individuals, especially children and adolescents. They have some usefulness for conducting research, identifying counseling goals for clients, and/or understanding a person's behaviors and world views (e.g., Bar On's Bar On Emotional Quotient Inventory, Mehrabian's Emotional Empathic Tendency Scale, and Balanced Emotional Empathy Scale).

Barrett-Lennard changed the one-dimensional perspective toward the measurement of empathy with his own theory which captures the complex nature of therapeutic empathy and offers a clear operational definition (Greenberg et al., 2011). Barrett-Lennard's cyclical model of empathy (1981) involved a sequential process model and showed how the therapist and client interact to create an empathic environment. The three phases of the model were empathic resonance, expressed empathy, and received empathy. Phase one involved "the inner process of empathic listening, resonance and personal understanding" on the part of the counselor. Phase two involved "communicated or (more accurately) expressed empathic understanding" from the counselor to the client. Phase three involved "received empathy, or empathy based on the experience of the person empathized with" which is experienced by the client (Barrett-Lennard, 1981, pp. 94-95). The cyclical nature of the process is facilitated by the metacommunication or feedback about the experience of being understood given by the client in phase three. This is followed by further expression by the client and the

opportunity for empathic resonance in the therapist and the cycle returns to phase one. It was noted by Barrett-Lennard (1981) that measures of empathy at each phase are not necessarily highly correlated with each other or with client outcome measures. High empathic resonance does not always lead to high empathic communication, and resonance and expression of empathy do not guarantee that it will be received. In a study by Kurtz and Grummon (1972), weak correlations were found between different measures of therapist empathy and client outcome. Barrett-Lennard demonstrated how the different measures tap different phases of the cyclical model and therefore were not expected to have a high correlation with each other or client outcome. Measures of received empathy such as the Empathic Understanding scale of the Relationship Inventory, rated by clients, were most closely tied to positive client outcomes. Measures of expressed empathy such as the Accurate Empathy scales of Truax and Carkhuff were not significantly correlated with the outcome composite index. Empathic resonance as measured by therapist ratings on the Relationship Inventory was least tied to positive outcome, with correlations approaching zero (Barrett-Lennard, 1981).

Elliott et al. (2011) have identified four categories for measuring therapist empathy within psychotherapy research and relate them to Barrett-Lennard's (1981) cyclical model of empathy. The categories include "empathy rated by nonparticipant raters (expressed empathy), client-rated empathy (received empathy), therapists rating their own empathy (empathic resonance), and empathic accuracy (congruence between therapist and client perceptions of the client)" (Elliot, 2011, p. 44). The current study was designed to evaluate previously video-recorded counseling sessions, making expressed empathy the most appropriate option for measurement. Therefore, the

following elaborates on the various options for third-party observers to measure expressed empathy.

**Observer-rated measures of empathy.**

***Rogers' Locus of Evaluation Scale.***

Of the observer-rated measures of empathy, most were influenced by the work of Carl Rogers and consist of a Likert scale the observer uses to gauge the expressed empathy of the therapist. Rogers (1951) presented research conducted by D. D. Blocksma on Rogers' counselor training program to demonstrate the learning of client-centered procedures. The counselors in training were rated on a five-point scale called Locus of Evaluation (p. 453), referring to how counselors were responding to the client. The items on the scale included:

(1) thinking and communicating completely *with* the expressed attitudes of the client, (2) thinking *about* and *with* the client, (3) thinking *about* the client, balancing the locus of evaluation inside and outside the client, (4) thinking and communicating *about* and *for* the client, (5) thinking *for* the client. (p. 453)

Each counselor response was coded as a negative two through a positive two, where (5) above was assigned a negative two, (4) a negative one, (3) a zero, (2) a positive one, and (1) was a positive two, which was considered the most empathic response.

***Truax's Accurate Empathy Scale.***

Truax and colleagues created a nine point Accurate Empathy Scale along with other similar scales measuring factors similar to Roger's core facilitative dimensions. The Accurate Empathy scale was an observer-rated measure of counselor response empathy. The nine points on the scale were considered anchor points along a continuum

of understanding of the clients' thoughts and feelings. Truax and Carkhuff (1965) presented the following examples of the low and high points on the scale:

*Low.* The therapist seems completely unaware of even the most conspicuous of the client's feelings. His responses are not appropriate to the mood and content of the client's statement and there is no determinable quality of empathy, hence no accuracy whatsoever.

*High.* The therapist... unerringly responds to the client's full range of feelings in their exact intensity. He expands the client's hint into a full-blown but tentative elaboration of feeling or experience with unerring sensitivity and accuracy. He is completely attuned to the client's shifting emotional content; he senses each of the client's feelings and reflects them in his word and voice. (pp. 120-121)

Truax (1972) reported correlations between the Accurate Empathy scale and other scales of understanding. He also noted that raters are trained to listen to therapist responses only as much as possible and are sometimes given only therapist responses to rate. It was his belief that the access to client content could interfere with appropriate ratings. Typically, raters had no background knowledge in psychology and were trained to rate short (e.g., three minute) audio clips randomly presented (Truax & Carkhuff, 1965). Truax's descriptions of high and low points indicate that both choice of words and tone of voice were essential to accurate ratings.

***Carkhuff's Empathic Understanding in Interpersonal Processes Scale.***

As part of his discrimination training program described in *Helping and Human Relations: A Primer for Lay and Professional Helpers* (1969) Carkhuff defined a series of 5-point scales to lead trainees toward an understanding of the facilitative dimensions

of counseling (empathic understanding, respect, concreteness, genuineness, facilitative self-disclosure, confrontation, and immediacy of relationship). The scale for empathic understanding was identified in the introduction as the measure chosen for the current study (see Appendix A). Carkhuff adapted Truax's 9-point scale into a 5-point scale. The Carkhuff Empathic Understanding in Interpersonal Processes Scale starts at Level 1, which indicates nonfacilitative responding where the counselor communicates less information than the client. Level 3 is considered minimally facilitative responding, essentially reflecting the feelings of the client. At Level 5, the counselor adds significantly to the information presented by the client, perhaps expressing accurate feelings beyond the person's own awareness. Carkhuff writes the following notes to allow those familiar with earlier versions to understand the modifications:

This scale is derived in part from "A Scale for the Measurement of Accurate Empathy," which has been validated in extensive process and outcome research on counseling and psychotherapy (summarized in Truax & Carkhuff, 1967), and in part from an earlier version that had been validated in extensive process and outcome research on counseling and psychotherapy (summarized in Carkhuff, 1968; Carkhuff & Berenson, 1967.) In addition, similar measures of similar constructs have received extensive support in the literature of counseling and therapy and education. The present scale was written to apply to all interpersonal processes and represents a systematic attempt to reduce ambiguity and increase reliability. In the process many important delineations and additions have been made, including, in particular, the change to a systematic focus upon the additive,

subtractive, or interchangeable aspects of the levels of communication of understanding. (Carkhuff, 1969, vol. 2, p. 315)

A study assessing the validity and reliability of Carkhuff's (1969) 5-point scale for measuring empathy found it to correlate highly with Truax's longer 9-point scale for measuring empathy, and to have high interrater reliability (Engram & Vandergoot, 1978).

***Cochrane's measure of empathic communication.***

Cochrane (1974) developed another measure of empathic communication. The measure attempts to identify more specific observable behaviors, including voice quality and vocal cues. Cochrane identified six common elements across different definitions of empathic understanding and created a six-item scoring rubric for rating units of communication. A counselor's response to a client statement is considered a communicative unit, and is scored for the presence or absence of each of the six elements. The elements include internal vs. external frame of reference, separation vs. fusion, accuracy vs. nonaccuracy, concrete vs. abstract, high energy vs. low energy, and caring vs. noncaring.

In Cochrane's evaluation of her rating scale, 18 graduate students enrolled in a client-centered practicum served as the subjects and responded to taped client statements. Sixty-one percent agreement was found between two judges for whole-tape scores and significant interrater reliability correlations were found for each of the six elements. The reliability of the items was stable across clients, though caring was the weakest in consistency due to a low frequency of occurrence. The elements were reasonably correlated with the Total Empathy score but were not too highly correlated with each other.

***The Lister Empathy Scale and the Response Empathy Rating Scale.***

Elliot et al. (1982) reported on the development of the revised version of the Lister Empathy Scale, renamed the Response Empathy Rating Scale. The newer version divided empathy into nine components: frame, inference, accuracy, here and now, centrality, words, voice, manner, and impact. Each component is measured on a five-point scale; however, the components were reduced to two factors, depth expressiveness and empathic exploration. Elliot et al. (1982) made several recommendations for improving on the scale including removing accuracy and voice components. They also split manner into collaboration and exploration. Several other new components were also suggested.

***Recent advances in the measurement of empathy.***

Currently social neuroscience researchers are examining empathy from a biological perspective using physiological responses in conjunction with client self-reports of perceived empathy. According to the Harvard Mental Health Letter (Measuring empathy during psychotherapy, 2008), researchers found that sweat could be an indicator of empathy because clients perceived more empathy when counselors were physiologically matching their state of arousal. An analysis of counseling conversations showed counselors elicited less empathy when they were talking frequently. Thus empathy requires listening and counselors cannot listen when they are speaking or planning what to say. This research may imply that frequent empathic responding may be disruptive as far as the physiological matching with the client, and that empathic responding need not be frequent to convey understanding.

According to those in the field of neuroscience, empathy appears to be a crucial element of psychotherapy as well as human communication in general. Watson and Greenberg (2011) explained how the discovery of mirror neurons has played a large role in the brain-based research on empathy. Mirror neurons are neurons that activate in an observer's brain to reflect the sensations of the person being observed, but are not the same as neurons which activate to alert us to our own experiences. This provides a neurological basis for Rogers' *as if* condition. The authors acknowledge that empathic capacity appears to be hardwired at birth yet may be improved through six strategies they outline for counselors to practice. These include counselors visualizing client experiences, paying close attention to their own bodies to identify feelings being activated, listening to the details of client experiences, distancing themselves from their own personal experiences to better take on another perspective, cultivating self-awareness and self-reflection, and learning to identify emotions from narrative and nonverbal behavior. The authors go on to define empathy from a social neuroscience perspective:

Empathy is a highly complex process that is more than just an epiphenomenon or a background condition of psychotherapy. Empathic understanding integrates information from multiple sources to identify the idiosyncratic meaning of experiences for different individuals. Empathic communication results from myriad processes occurring in the brain. It is a synthesis of complex information processing at multiple levels that facilitates human interaction and survival.

Empathy is essential to interpersonal communication in every relationship and is a

highly sophisticated skill that, when applied or used in the context of psychotherapy, can be very healing. (Watson & Greenberg, 2011, p. 134)

### **Summary**

In summary, the impact of animals on human behavior in both therapeutic and casual interactions is well documented. The research showing reduced signs of stress in humans related to the presence of a calm animal suggests that the benefits of animals in therapeutic settings may extend to clients, counselors, and other staff members. Because empathic responding plays a role in establishing a positive therapeutic relationship in most types of psychotherapy, it is possible that this aspect of counselor behavior may be noticeably improved by a less stressful environment.

The measuring of counselor empathy is a widely debated subject which has not been consistently improved upon over the last century. Recent research is now turning away from verbal and behavioral content and examining physiological matching with the client's levels of arousal. While physiological studies may offer important insights into counselor empathy, it fails to address the cognitive processes involved with the communication of empathy to a client. Measures developed from the 1950s through the 1980s measuring counselor verbal and behavioral responses remain the most widely cited for observer-rated measures of response empathy.

The current study examined counselor empathic responding with and without a therapy dog present in therapy sessions. Based on the research presented above, it was hypothesized that counselors would offer more high quality empathic responses and fewer neutral or low quality responses when working with the therapy dog.

### **Chapter 3**

#### **Method**

A within subjects design was used to examine counselors' use of empathic responding in the presence of a therapy dog. It was decided that AAT was an appropriate intervention to be used in conjunction with other therapeutic activities. The counselors had met with the clients before using AAT. Aside from the addition of the dog, they continued to conduct treatment as they deemed appropriate for each client. The therapy dog was present for approximately half of each session. Sessions were previously recorded for training purposes, and later, when permission was granted to use the recordings for research, counselor responses were coded for level of empathic responding, and the data was used for the following analysis.

#### **Participants**

The primary participants in this study included seven second-year school psychology graduate student clinicians completing a practicum in a university-based mental health training clinic. All seven counselors were female. The counselors' training included basic counseling skills, such as an open posture, eye contact, active listening, and empathic responding. Counselors were also trained in conducting the most common approaches to psychotherapy, as well as AAT. In order to use the therapy dog, Sam, in client sessions, the graduate student clinicians underwent training with one of the dog's certified handlers. The clinicians learned the commands that Sam was taught and how to incorporate him into interventions to meet the individual client's treatment goals. Training in AAT also included required reading about using dogs in therapy. Skills were practiced by role-playing with peers and supervisors prior to clinical work. During these

sessions, the counselors were video and audio recorded to allow for peer and supervisor feedback. Counselors generally completed a year-long practicum, but some counselors returned for a second practicum and occasionally saw a client for two years, as occurred with Child Z. Two additional counselors worked with the clients in this study, and saw them for half of an academic year, January to May. Their tapes were used for training the coders in this study, but were not included in the analyses because they did not use AAT. All of the clients' following counselors used the therapy dog as deemed appropriate in their sessions, and all sessions including both with and without dog conditions were used for analysis.

Two brothers (Child Y and Child Z), elementary school aged at the time of treatment, were the client participants in this study. Child Y was diagnosed with an Adjustment Disorder with Mixed Disturbance of Emotions. Several environmental factors were indicated as stressors including family changes and problems with school related to a lack of behavioral control. The highest Global Assessment of Functioning (GAF) reported for the year prior to the start of treatment at the clinic was in the 51-60 (*moderate symptoms*) range. Child Y saw a total of five counselors over nine semesters. It was common for clients who attended the clinic to change counselors at the end of an academic year. Treatment goals remained consistent across time and included improving self-expression, recognition of emotions, positive coping skills, problem-solving skills, and empathy to reduce aggression and improve relationships with others.

Child Z was referred to the clinic with a report indicating a diagnosis of Intermittent Explosive Disorder. He was faced with the same environmental stressors as his brother. The highest GAF reported for the previous year was in the 51-60 (*moderate*

*symptoms*) range. Child Z saw four counselors over nine semesters and his treatment goals were also consistent across the years he attended the clinic. Treatment goals for Child Z included decreasing anger and aggression, increasing understanding of his emotions, expression of problems and emotions, positive coping strategies, empathy for others, and a positive sense of self. Three counselors used the therapy dog for some of their sessions with Child Z, and one of them stayed with him for two consecutive years.

### **Treatment conditions**

The independent variable was the presence of the therapy dog. It had two conditions—*dog present* and *no dog present*. The dependent variables included the level, from one to five, of the empathic responses made by the counselor and the number of empathic responses at each level.

#### ***Therapy dog.***

Sam, a Labrador retriever, participated in client sessions during the animal-assisted therapy component of the clients' treatment plans. Sam qualified as a certified therapy dog under the regulations of the Pet Partner's standards for canine assistants. Sam was purchased at the age of two from a program which trains dogs to assist children and adults with disabilities (e.g., the dogs provide balance for individuals with physical disabilities, signals for individuals with hearing disabilities, companionship for children with autism, and assistance to health care providers). Three faculty members of the school psychology department at the university in which the study was conducted attended a comprehensive, intensive training provided by the service dog trainers. Sam and the handlers underwent a recertification exam annually. Sam's training included basic obedience skills, exceptional manners, and activities such as retrieving items,

carrying objects and releasing them on demand, walking next to the counselor or client, and performing simple social interactions, such as giving the client or counselor his paw (Engel, 2011).

## **Measures**

### **Empathic Understanding in Interpersonal Processes: A Scale for Measurement (Carkhuff, 1969).**

Level of counselors' empathic responding as described in Chapter 2 were rated using Carkhuff's Empathic Understanding scale (see Appendix A). As mentioned in the literature review, one study found this scale to have high interrater reliability, and this was all that was available although Carkhuff's work is widely referenced in the literature on empathic responding. An advantage of the Carkhuff scale was its simplicity. Most other measures required coders to distinguish between more than five levels or dimensions other than word choice such as tone of voice and body language. Coders also used additional guidelines created from the training process to determine empathic understanding ratings when viewing counseling sessions including young children and play therapy activities (see Appendix B).

The empathic understanding scale did not clearly define how to separate counselor utterances, probably because it was clear reading a transcription or listening to the recorded talk-therapy sessions that each time the counselor spoke it was in response to something the client had said. In the case of play therapy, the counselor often responded to behavior and expressions of the child without a clear back-and-forth verbal exchange. Therefore, it was necessary to define how to separate counselor utterances

into discreet items for transcribing the sessions used in this study. Appendix B also gives the coders guidance on transcribing utterances.

### **Procedure**

Recordings of previously completed sessions were used for analysis. The recordings were selected for coding if they met the agreed upon conditions. The first condition was that the therapy dog was present for part of the session and not present for part of the session so that the treatment conditions could be compared within the same session. Only individual counseling sessions were used (family sessions excluded), and only the recordings that were available and of sufficient sound and video quality to be accurately coded were selected.

In the sessions, counselors for both children used a combination of play therapy, talk therapy, family therapy, and AAT. Play therapy was mostly non-directive and child-centered, with the counselor allowing the child to choose an activity such as painting, playing in the sand box, building, or playing a board game. During play therapy, the counselor engaged in the play, as directed by the child, while reflecting aloud on the child's comments, questions, and behaviors. Talk therapy mostly consisted of cognitive-behavioral therapy with the therapist guiding the child to think through their experiences and make connections between thoughts, feelings, and behaviors. The counselors also instructed the child on topics such as anger management by teaching appropriate coping strategies and problem solving skills with structured games and worksheets. Family therapy included some structured play sessions where the children could practice communication and cooperative skills with each other and caregivers. The therapy dog was used to build rapport, increase participation, increase empathy, and improve

assertiveness. Activities included giving the dog commands and rewarding him with treats, petting the dog, talking to the dog, including the dog in games, and for Child Z, reading to the dog. AAT was used for approximately half of the total session time during any one session (e.g. 20 minutes of AAT in a 45 minute session). Table 1 describes the total number of sessions for each client and counselor, as well as those that met the criteria for coding. The total number of sessions coded for Child Y was 21 and the total for Child Z was 18.

The counseling sessions were structured as 45-50 minute sessions, and the therapy dog was usually brought to the room near the beginning or middle of the session and usually stayed for 10-30 minutes. Both boys typically attended counseling at the same time, and the brothers alternated having the dog first or second from week to week.

Informed consent was obtained from the clients' guardian and graduate clinicians. The clients' guardian had initially given permission for the video recording of counseling sessions for the supervision and training of the clinicians. At the start of this study, the client's guardian also granted permission for the tapes to be used for research. The graduate clinicians granted permission to use tapes of their counseling sessions for research at the start of this study. Approval for the study was obtained from the university's research review board.

#### ***Video-coder training.***

School psychology graduate students were recruited to code the counselor responses. The coders read and signed a confidentiality agreement before the training began. In order to eliminate the possibility of gender bias, either an equal number of male and female raters, or raters of all the same gender were preferred (per Eisenberg &

Lennon, 1983). The potential coders available to begin training included two males and four females. However, the coders who ultimately met interrater reliability included one male and two female students.

The training consisted of a review of Carkhuff's rating scale and definitions of each level of empathic understanding (see Appendix A). As discussed previously, necessary additional guidelines were developed and documented to accompany the scale (see Appendix B). Coders reviewed video segments and discussed as a group the appropriate ratings for each utterance. They then coded some utterances independently and came back together to discuss the reasons for any discrepant scores. The video segments used in the training sessions included the same two clients who were in the study with their first two counselors (not included in the study). One counselor was male and the other was female. No therapy animal was present in the sessions used for training. Coders then independently transcribed and coded a full session at a time (transcribing only the counselor utterances) and met again in groups or with the trainer to discuss discrepancies. See Appendix C for a blank video coding record. Changes to the additional guidelines were developed as coders discussed points of confusion, and clearer definitions of transcription and coding guidelines emerged. Once interrater reliability (IRR) was established with the first coder, the additional guidelines for coders remained unchanged.

Coders rated training sessions until the IRR standard was met. IRR was determined by comparing each coder's ratings for a session to the ratings of the trainer using a Cohen's analysis. Coders were required to meet or exceed a kappa level of 0.67. A kappa of .61 – .80 is considered to be in the range of *substantial agreement* (Landis &

Koch, 1977), and Krippendorff (1980) suggests that 0.67 – 0.80 be used for *tentative conclusions*. After coders completed their first three sessions of data coding, agreement was reassessed with an additional training session. Two coders met the IRR standard after coding the 3<sup>rd</sup> training video, and a third coder met IRR after the 4<sup>th</sup> training. The other coders dropped out of the training process due to timing; they had not met IRR by the end of the academic year.

### ***Coding procedure.***

Only the sessions including the therapy dog were coded for the data analysis. One rater transcribed and coded each digitized video session. Coders rated an entire session to attempt to prevent them from identifying the research question and to increase accurate understanding of the context for the counselors' responses.

The sessions presented for coding were systematically randomized to control for any difference in coders and changes in coding patterns over time. To randomize the sessions, they were listed in order of date, first Client Y and then Client Z, and assigned a number (one through five) until the numbering started over. The sessions were then sorted by the numbers they were assigned into five groups for coding. It was anticipated that five coders would be used at the time the first coding began. However, two of the coders were only able to get through two or three sessions, and one coder completed the remaining 34 sessions. This coder was assigned one group at a time until all five groups were complete. Each group contained sessions from both clients and early and later sessions from each counselor. See Table 2 for a description of the training sessions and reliability data collected from each coder.

## Chapter 4

### Results

This study examined the relationship between the presence of the therapy dog and counselor empathic responding. The dog present and no dog present conditions were compared measuring the frequency of each level of empathic responding. Potential levels of empathic responses ranged from one (low empathy) to five (high empathy). No Level 5 utterances were offered by the counselors; therefore, this level has been excluded from the analysis. Repeated measures analysis of variance (ANOVA) were used to compare the levels of empathic responding across the dog and no dog conditions. For the purpose of these analyses, the presence of the therapy dog and the level of empathic responding of the counselors' utterances, Levels 1 to 4, were considered independent variables. The dependent variable was the frequency of the utterances. Significant differences were determined by *p*-values less than .05. IBM SPSS Statistics 23 software was used for all statistical computations.

Two ways of evaluating the frequency data were used: utterances per minute and percent of total utterances. Each condition (with and without the dog) within a counseling session varied from 5 to 35 minutes in length. To control for the difference in length of each tape segment, frequency data for each condition was converted into a percentage of utterances per total time in minutes. The counselors in the study also differed in the average number of utterances they used per session. Therefore, frequency data for each level of empathic responding was divided by the total utterances in the session condition. This showed the percent of the total utterances that fell into each level of the empathic understanding scale and how the balance shifted across conditions.

Differences in the counselor empathic responding were assessed using two repeated measures ANOVAs. This type of analysis tests for the difference between means in related groups. The two ANOVAs included an analysis of the utterances per minute scores and the percent of total utterances scores. Ratings for Level 1 utterances per minute for the dog condition for all of the counselors were combined and all of the counselors' ratings for the no dog condition were also combined. Therefore, all counselors' sessions were grouped into dog and no dog conditions, and the same was done with each level of empathic responding. There were 18 sessions with Child Y and 21 sessions with Child Z that met the criteria for coding and were included in the analysis ( $N = 39$ ). Only the counseling session containing dog and no dog conditions within the same session were used for the analyses.

Most counseling session recordings had a few utterances that the coders noted as inaudible. Inaudible utterances were recorded sounds that were difficult to hear, and the coder could not determine what was said or who was speaking. These inaudible utterances were labeled *not rated*, and the frequency of these not rated utterances were totaled for each session condition, combined across counselors, and analyzed for a difference between conditions. There was no significant difference in the number of not rated utterances per minute between the dog and no dog conditions using a paired-samples *t*-test, dog  $M = 0.16$ , no dog  $M = 0.16$ ,  $t = -0.01$ ,  $p = .99$ , 95% CI [-.05, .05].

### **Analysis of Utterances per Minute**

The utterances per minute scores were entered into a 2 (Dog Presence) X 4 (Empathy Level) repeated measures ANOVA. Sphericity was assessed using Mauchly's Test and was significant for the main effects of Empathy Level and the Dog Presence X

Empathy Level interaction, indicating a violation of the sphericity assumption (that there is equal variance of the difference between the levels of the independent variable). The Greenhouse-Geisser correction was applied for those  $F$ s, adjusting the degrees of freedom used to calculate significance.

The ANOVA revealed a significant main effect of Dog Presence [ $F(1, 38) = 6.84, p = .013, \eta p^2 = .15$ ]. Overall, the counselors made significantly more utterances per minute when the dog was present ( $M: 3.25$ ; CI 95%: 2.84 – 3.66) than when it was not ( $M: 2.77$ ; CI 95%: 2.38 – 3.15). The ANOVA also revealed a significant main effect of Empathy Level [ $F(1.8, 68.4) = 150.90, p < .001, \eta p^2 = .80$ ]. Post hoc tests using Bonferroni pairwise comparisons indicated that every Empathy Level differed significantly from the others (all  $p$ s = .027 or less). There were significantly fewer Level 4 utterances ( $M = 0.13$ ) than Level 3 utterances ( $M = 1.41$ ), which was significantly less than the number of Level 1 utterances ( $M = 2.42$ ). The most frequent utterances were at Level 2 ( $M = 8.06$ ). The effect sizes for both Dog Presence and Empathy Level were in the large range by Cohen's suggested descriptors for partial eta squared (Richardson, 2011). Post hoc power calculations were done using G\*Power 3.1 (Faul, Erdfelder, Buchner, Lang, 2009). The power for the main effect of Dog Presence was 97% and the power for Empathy Level 100%, both indicating a high probability that the observed difference is a true difference and that the sample size was sufficient.

The significant main effects can be further explained by a significant Dog Presence x Empathy Level interaction [ $F(1.7, 64.8) = 7.80, p = .002, \eta p^2 = .17$ ]. Effect size was in the large range and power was calculated as 90%. Post hoc comparisons using the Bonferroni procedure revealed that the counselors made significantly more

Level 1 responses when the dog was present than when it was not ( $M_s$ : 3.19 vs. 1.66, respectively), but there were no significant differences between the Dog-Present and Dog-Absent conditions in the number of Level 2, 3, or 4 responses. Additionally, the post hoc comparisons revealed that when the dog was absent, the number of Level 1 and Level 3 responses were equivalent ( $M_s$ : 1.66 vs. 1.56, respectively) (See Table 3).

### **Analysis of Percent of Total Utterances**

The analysis of the percent of total utterances scores using a 2 (Dog Presence) X 4 (Empathy Level) repeated measures ANOVA helped to confirm the previously mentioned results. Again, Mauchly's Test was significant for the main effect of Empathy Level and the Dog Presence X Empathy Level interaction, and the Greenhouse-Geisser correction was applied for those  $F_s$ . The Dog Presence X Empathy Level interaction was significant [ $F(1.7, 65.2) = 17.85, p < .001, \eta p^2 = .32$ ]. Effect size fell in the large range and power was calculated as 95%. A pattern similar to the utterances per minute analysis was found using a Bonferroni post hoc comparison for the simple effect of the dog on empathy levels. There were significantly more Level 1 utterances as a percent of total utterances when the dog was present compared to when the dog was not present ( $M_s$ : 23.53 vs. 13.73, respectively). Due to more Level 1 utterances when the dog was present, Level 2 and Level 3 utterances were significantly lower in the dog present condition than in the dog not present condition. No significant difference was found between Level 4 scores with and without the dog present (See Table 4).

A visual review of the Level 1 utterances in the video coding records was done after the analysis to better understand the reason for the significant difference observed. There appears to be a large number of Level 1 responses that are directed to the dog, such

as verbal commands or praise, in the dog condition compared to the no dog condition Level 1 responses. Table 5 shows some of the types of responses coded as level 1 that occurred when the dog was present.

## **Chapter 5**

### **Discussion**

This study used a within subjects design to examine the difference between counselor empathic responding with and without a therapy dog in the counseling sessions. This appears to be the first study that systematically examines a change in counselor behavior during AAT sessions. The results of the study did not support the hypothesis that the counselor would demonstrate higher empathic understanding and would respond with a greater frequency of high empathy utterances when in the presence of a therapy dog. This chapter will discuss the findings, benefits and limitations of the design, and directions for future research.

#### **Benefits of the Design**

The benefits of having the same clients and therapy dog used across multiple counselors made this data ideal for studying the within-subject differences in counselor empathic responding. The variables associated with different clients such as personality and response style were controlled for, as well as variables in the temperament and training of therapy dogs. Having the dog present for only half of each session allowed the counselors to be compared to themselves at a very close point in time, eliminating the change over time in their behavior due to training and experience.

The coders who transcribed and rated counselor empathic responding met a reasonably high standard for interrater reliability for a construct which is difficult to define and measure. It appeared that the scale and additional guidelines used in this study were consistently applied and that interrater reliability increased with an increased frequency of practice with the coding procedure. Therefore, the findings are believed to

be an accurate assessment of a change in the pattern of responding demonstrated by these counselors in the context of this study. The effect size of the impact of the dog on counselors' Level 1 responding was in the large range, whether considering the utterances per minute or the percent of total utterances analyses. The power calculation for both analyses suggest that there was a 90% chance or higher that the observed difference is true and that the sample size was sufficient to have confidence in the observed difference.

### **Counselor Utterances**

Contrary to the hypothesis, the most prominent finding in this study was that the addition of the dog to the counseling setting resulted in more utterances, but these additional utterances were primarily low empathic utterances (Level 1). The rate of all higher-level empathic responses, Levels 2 through Level 4, was the same across dog and no dog conditions. After a review of the coding records, it appears that the most common of these additional low empathy utterances in the presence of the dog were commands and praise spoken by the counselor to the dog. This difference may be due to a combination of two factors: the AAT activities may have been more directive than the non-AAT activities and the dog may have served as a distraction during the counselors' observations of the child.

This finding can be viewed at least two ways. When coding the videos in this study, the coders considered that every time the counselor spoke there was an opportunity to express empathy. Any statement that did not express empathy was rated as low empathy on the empathic responding scale. Therefore, there was no "other" category for responses that were necessary but not empathic, such as procedural statements or talking

to the dog rather than the child. Other researchers could interpret the results differently if they considered that sometimes the Level 1 responses were necessary and procedural and other times they were actually missing opportunities to express empathy. This would mean thinking of empathic responding as an option that is not always present, so they would not consider all the reported Level 1 responses in this study as low empathy. This would mean that counselors were adding something verbal to the therapy during the dog present condition, but were not being any less empathic because a significant difference was not observed at the higher levels of the empathic responding scale in this study. Furthermore, the counselor expressing praise toward the animal could be considered an expression of empathy, directed at the dog rather than the client. It is possible that the counselor expressing empathy toward the animal might have some vicarious benefits for the client. The clients in this study reported that greatly enjoyed having the dog in their sessions. The counselors' kind words toward the dog may have helped to children to view their counselors as more empathic.

#### **Level of empathic responding.**

Another prominent finding of the study was that counselors had far more Level 2 empathic responses than any other level. These are below the minimally facilitative, Level 3 through Level 5, empathic utterances that Carkhuff (1969) felt counselors should be aiming to achieve. The high level of common conversational exchanges, Level 2 utterances, observed in this study may be partly due to these being counselors in training who were also working to build rapport with early elementary aged clients. The counselors had not yet developed a strong sense of empathic responding, and at the same time, the counselors may have felt that they needed to talk to their client in a way that he

could relate to, using common expressions and praise (e.g. “cool,” “awesome! “nice job”). All of these expressions were generally rated as a Level 2 on the scale used because they demonstrated the counselor’s judgement of something other than the client’s thoughts or feelings.

### **Limitations**

#### **Clients.**

There were several limitations to the present study. The first was that there were only two clients, elementary-aged twin boys, which limits the generalizability of the findings. These two clients were observed across four years of counseling, reducing the variability of different children bringing different styles of interacting and communicating with their therapist. A limitation of having this consistency is the inability to draw conclusions about therapist interactions with a broader range of client characteristics such as different ages, gender, personalities, behaviors, and symptoms. Another potential limitation related to using the same clients year after year is that as they grew older, they had to form new relationships with counselors each school year. The children in this study also had declining attendance by their third and fourth years of counseling. As they aged and perhaps gained more independence and coping skills, these clients may have become less engaged with their counselors or disinterested in continuing therapy, reducing the opportunities for building strong empathic relationships with their counselors.

#### **Therapeutic approach.**

The results are also limited to the play therapy setting where the children were engaged in a variety of games and activities. There was some variation in the frequency

of counselor utterances depending on the activity in which they were engaged. Some activities required straightforward directives in addition to opportunities for empathic responding (e.g., reading the rules of a game, counting out pieces or spaces on a board, answering questions about game). At times, the counselors needed to give more directives about how to train and behave around the therapy dog as part of the AAT counseling objectives. In the play therapy sessions in this study, the dialogue was restricted by the less personal focus of some of the activities involved. The many exchanges about what was happening during a game (e.g., “oh, you got a blue one,” “oh no, you’re getting ahead,” “nice job!”) were mostly low level empathic responses. The high-level empathic responses occurred so infrequently that there may not be enough data to conclude that there was no change in the Level 4 empathic utterances, and there was no observations of Level 5 responses. In contrast, clients engaged in predominantly talk-therapies might present their counselors with more opportunities for in depth understanding and empathic exchanges, allowing a better assessment of the impact of a therapy animal on high level empathic responding.

#### **Counselors level of training.**

The counselors used in this study were all second or third year graduate students. Therefore, the results are limited to early career counselors with little to no experience, especially with AAT. As stated previously, the differences observed with and without the therapy dog present are potentially a reflection of the counselors being burdened with managing the dog’s behavior in addition to the counselor-client relationship. This might be a more likely explanation for novice counselors than those with more experience in the field.

Being new to counseling, these counselors were juggling a number of new tasks and objectives during their sessions. For example, these graduate student counselors had to apply a variety of strategies and counseling techniques including providing clear boundaries and expectations. They had to engage young children without imposing too much of the counselor's preferences on the child's choice of games, role-play scenarios, and topics of conversation. They had to try to understand and respond to the child's perspective, teach new strategies for managing conflict and emotions, and conduct these tasks while being video recorded and evaluated on their progress by peers and supervisors. This added to the pressure on counselors to perform at a high standard.

As noted by the counselors interviewed in Blankley's study (2003), applying AAT strategies in addition to these tasks was more demanding because counselors had to attend to the needs and behaviors of the client and the animal. The therapy dog in this study also required more verbal utterances from the counselor to manage the dog and teach appropriate dog handling skills to the child. All of these challenges may have been less of a distraction to an experienced counselor who would be more fluent with empathic responding as well as other therapeutic techniques. For example, a counselor who is teaching the child to handle the therapy animal might still give more low empathy utterances to manage the animal (e.g., "sit," "stay," "good boy,") but would do this with more automaticity than a counselor new to AAT. Being able to do this automatically, they might also be more aware of the child's experience with the dog and able to reflect on it with higher level empathic remarks (i.e., "you look pleased that he is following your commands," "you like it when he wags his tail at you," "it is relaxing to pet him,").

Therefore, an experienced counselor could exhibit a different balance between additional low and high level empathic utterances while using AAT.

### **Therapy dog.**

In addition to the clients and counselors used in this study, the third *participant*, a single therapy dog, also presents a limitation of the generalizability of these finding. This study used one dog across all sessions, and he was a service dog that required a high standard of consistency among all handlers. Very specific commands and rewards had to be used by all counselors, requiring a lot of attention to detail when working with him. Not all animals used in therapy require the same level of training and management and could be less demanding of the counselor's attention. Furthermore, each animal brings its own personality and characteristics to the therapy sessions, and exploring the impact of different animals on counselor empathic responding might lead to contradictory findings. However, the consistency of having one dog across all sessions also provided less variability for the study design. The dog provided consistency for the clients, especially since they changed counselors each year, and the dog gives more opportunity to observe a difference in the study's conditions because there is less variability in the dog present condition due to using the same dog each time.

### **Measurement.**

Another limitation involved the ability to maintain the validity of the empathic understanding scale of measurement. The Carkhuff scale was chosen in part based on its simplicity of use, only five levels to discriminate between, and its familiarity as it related closely to the instruction in interpersonal skills taught in the coders' graduate training program. However, even Carkhuff's scale, which had demonstrated validity and

reliability, could be compromised by the use of new coders and additional guidelines. In order to relate the scale criteria to play therapy sessions conducted with young children and clarify discrepancies between coders, a number of additional criteria had to be defined and added to the original scale. Therefore, readers should be cautious to assume that the scale has maintained its validity and is measuring the same construct as originally defined by its author.

### **Coding process.**

Finally, the rigor of the coding process was somewhat limited by the availability of coders. There was a small number of graduate assistants available for data collection, so the decision was made to use only one coder per session to reduce the total time required by any one person. Ideally, more coders would have been used to rate the counselor utterances, and more than one coder would view each session and reach agreement with other coders, giving more reliability to the process. Secondly, the majority of the sessions were coded by the same person due to limited success with training the coders and the fact that the school year was ending as several coders were just beginning to collect the data. However, after entering the data from the coding records, it appears that the primary coder for this study consistently applied the scale criteria to each video after reliability was established and reassessed. Another coding limitation was that the training process was slowed by training both the guidelines for separating utterances when transcribing counselor verbalizations and the guidelines for applying the empathic rating scale to the utterances. Had additional coders been available, it would have been more consistent to have one person transcribe the sessions and the others coding them.

**Directions for Future Research**

Replications of the current study design are necessary to confirm that the coding process and interrater reliability standards achieved are repeatable and rigorous enough to detect real changes in counselor empathic responding. To further address some of the limitations of this study, future research should include designs with a broader range of therapy animals, clients, and counselors, especially counselors experienced at conducting AAT.

The current study was unable to determine possible changes in higher level empathic responses due to a limited number of Level 4 response and no observed Level 5 responses. A study examining experienced counselors who use empathic responding as a core principal of their therapeutic approach may be better suited to look at the impact of a therapy animal on high level empathic responding. Particularly, a therapy animal used in talk therapy rather than play therapy might not lead to a noticeable increase in low empathy responses.

The findings suggest that practitioners consider whether counselors in training or early career counselors need more time to solidify the core interpersonal skills of therapy before incorporating a therapy animal into their work. Identifying when a counselor is able to attend to an animal without sacrificing meaningful interactions with the client is unclear from this study. To better evaluate this question, researchers should look at the differences in core interpersonal skills with and without an animal present for counselors at different stages of their career, as well as counselors who are more experienced at AAT.

Related research questions might include examining other methods of measuring empathy. Counselor and client self-reports, other scales for observer-rated empathy discussed in the literature review, and physiological measures of empathy should be considered. Looking at changes in counselor empathy using different measures of the same construct would help to clarify if the observed results found in this study are indeed an indication of a change in empathic awareness of counselors working with a therapy animal.

If similar observed differences are found in future studies, the next steps should include an assessment of treatment outcomes to determine if a change in counselor empathic responding has a measurable effect on reaching treatment goals. It would also be advisable to consider that the therapy animal has an impact on counselor behavior in areas other than empathic responding which may have a positive impact on treatment outcomes. Future research might include measuring counselors' behavior using the other dimensions of counselor effectiveness identified by Carkhuff (i.e., communication of respect, concreteness or specificity of expression, genuineness, facilitative self-disclosure, confrontation, and immediacy of relationship). Counselors could also be measured on their ability to apply other techniques required in play therapy or cognitive-behavioral therapy such as interviewing, role-play, modeling, managing behavioral reinforcement plans, mindfulness strategies, social stories, limit setting, etc.

### **Implications**

The results of this study lead to questions about the ability of beginning counseling students to express empathy at a high level. If the level of experience of counselors in this study was a limiting factor on the span of empathic responding, then

careful consideration should be given to the training process used with new counseling students. It took a significant amount of time for new coders in this study to understand and utilize the empathic understanding scale. These coders, also being first and second year counselors in training, provided some insight into the hands-on practice necessary to comprehend and evaluate empathic responding. Training was most successful when coders were able to rate a full session of counselor responses and then meet to discuss their observations with the trainer within a week's time. When practicing the coding this way, the coders improved quickly. Repeated practice rating responses and discussing the ratings with other coders helped to clarify what strong empathic responding was and how to identify it. The coders reported that this practice was helpful in their preparation for counseling practicum experiences. Peer evaluation in a clinical training setting can provide the same practice when using a framework like the empathic understanding scale.

In addition to the lower range of empathic responses issued by these counselors in training, the increase in low empathic responses in the presence of a therapy dog suggests the need to be cautious when adding an animal to the therapeutic process. The animal also requires attention from and interaction with the therapist. Due to the demands an animal may place on the counselor's attention and unanswered questions about the impact of this observed change, it may be advisable to establish a level of general competency with counseling skills before initiating animal-assisted therapy training.

### **Summary**

Empathic responding has been shown to be an important part of interpersonal communication, relationship building, and a facilitative aspect of many therapeutic approaches. It has also been shown that animals incorporated into therapeutic settings

communicate something like empathy, positive regard, and acceptance to clients through their behaviors. In the current study, consistently across counselors, the data showed that there was a change in the dog condition; counselors used more of the lowest level of empathic utterances when incorporating a therapy dog into their sessions. It is not clear how the clients interpreted the addition of these practical utterances. Although they may have viewed the counselor as less empathic, they may also viewed the counselor as being responsive to the dog. More research is necessary to explain how counselors and therapy animals interact and how to capitalize on the benefits of AAT when combining it with other therapeutic techniques.

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Table 1

*Counseling Session-Log Data for Child Y and Child Z*

Counselor	Year	Total Sessions Attended	Cancellations/ No Shows	Therapy Dog Attended	Coded Sessions <sup>a</sup>
Child Y					
Intake					
Counselor <sup>b</sup>	1	11	0	0	0
Counselor A	2	20	5	7	6
Counselor B	3	16	7	10	8
Counselor C	4	15	3	5	3
Counselor D	5	12	10	3	4
<b>Total</b>		<b>74</b>	<b>25</b>	<b>25</b>	<b>21</b>
Child Z					
Intake					
Counselor <sup>b</sup>	1	14	1	0	0
Counselor E	2	20	5	6	5
Counselor F	3-4	32	12	14	12
Counselor G	5	12	10	3	1
<b>Total</b>		<b>78</b>	<b>28</b>	<b>23</b>	<b>18</b>
<b>Total (Y&amp;Z)</b>		<b>152</b>	<b>53</b>	<b>48</b>	<b>39</b>

<sup>a</sup>Sessions used for coding included only those with both the dog present and dog not present conditions.

<sup>b</sup>Intake counselors worked with the clients from February to May of their first year of counseling. They did not use the therapy dog in their sessions. Video recordings of these sessions were used for training coders.

Table 2

*Video Coding Training Log and Interrater Reliability Data*

Coders	Training	IRR Kappa	Determination <sup>a</sup>
1	A	N/A <sup>b</sup>	Continue Training
	B	N/A	Continue Training
	C	.731	Begin Coding
	E <sup>c</sup>	.662	Re-train Withdrew from Training
2	A	N/A	Continue Training
	B	N/A	Continue Training
	C	.532	Continue Training
	D	.684	Begin Coding
	E	.904	Continue Coding
3	A	N/A	Continue Training
	B	N/A	Continue Training
	C	.694	Begin Coding Withdrew from Training
4	A	N/A	Continue Training
	B	N/A	Continue Training
	C	.473	Continue Training Withdrew from Training
5	A	N/A	Continue Training
	B	N/A	Continue Training
	C	.410	Continue Training Withdrew from Training
6	C	N/A	Continue Training
	D	.429	Continue Training Withdrew from Training

<sup>a</sup>IRR Kappa of .67 or higher was used to determine sufficient agreement for coding data.

<sup>b</sup>Kappa was not assessed in early training sessions. Feedback from coders was used to adjust coding guidelines.

<sup>c</sup>Training Video E was used as a reliability check after those who had begun coding for data completed three sessions.

Table 3

*Utterances Per Minute: Means and Standard Deviations for the Empathy Level X Dog Presence Interaction*

Empathy Level	Dog Present Means (SD)	Dog Not Present Means (SD)	Empathy Level Means <sup>a</sup>
Level 1	3.19 (2.41)	1.66 (1.94)	2.42
Level 2	8.43 (3.68)	7.69 (3.33)	8.06
Level 3	1.26 (0.82)	1.56 (1.11)	1.41
Level 4	0.10 (0.14)	0.16 (0.20)	0.13
Total Means	3.25	2.77	-

Note. Grand mean = 3.01.

<sup>a</sup>The total means for each level of empathy when dog present and dog not present conditions are combined.

Table 4

*Percent of Total Utterances: Means and Standard Deviations for the Empathy Level X Dog Presence Interaction*

Empathy Level	Dog Present Means (SD)	Dog Not Present Means (SD)	Empathy Level Means <sup>a</sup>
Level 1	23.53 (12.15)	13.73 (12.12)	18.63
Level 2	64.34 (12.21)	70.09 (12.74)	67.22
Level 3	11.21 (10.55)	14.26 (9.48)	12.74
Level 4	0.91 (1.22)	1.33 (1.41)	1.12
Total Means	25.0	24.85	-

Note. Grand mean = 24.93

<sup>a</sup>The total means for each level of empathy when dog present and dog not present conditions are combined.

Table 5

*Examples of Counselor Utterances at Each Level of Empathic Responding*

Level 1	<p>Oh man  Ooo that was a good card  We also have some over here  Excuse me a minute  I go on the white, right?  How did I miss that?  You have 5 minutes left before time to go  Remember one of my rules is not to hurt yourself or break toys  Alright, time to go  <i>All comments spoken to the dog:</i>  Say hello Sam  Sam sit  Sam down  Good boy (to the dog)  Leave it  Sam off  Goodbye Sam</p>
Level 2	<p>It's kinda like a thick syrup  Oh you sure do  I think you're right  How come?  Want to do a different game?  Well what game do you want?  I'm going to give the choice to you  Ok  Hmmm  Good move  Good job  That's a good idea  Alright  I don't know  You're right, it is a tie  What's that?  Sure  Yup  What color should i be?</p>
Level 3	<p>It does look like I have you trapped  Looks like your bullseye  He got you right in head, that must hurt  I know, you haven't moved in a long time</p>

<p>Level 3</p> <p>Cont.</p>	<p>That's what happens 2 you?          You think I'm going to get Jolly?          So you want to eat everything but markers?          You're gonna be green instead          Time for the punching bag          He's missing an eye          Drawing some sharp teeth on the vampire...          Looks like you drew a whole body          Your shoving his head right down          Looks like your hurt          You kicked him          You got him right back          I have to count till time to leave?</p>
<p>Level 4</p>	<p>You don't want to win?          You really like to go right away          You really don't want me to win          Seems like you really want me to choose          You don't want to jump it          You like to get that middle spot          You really like going first          Blue seems to be your favorite color          You want to be here longer than an hour?          You really like to draw on him          You seem really excited about it          I think you're getting mad          I think you're getting disappointed          You really want to hurt the vampire</p>

## Appendix A

### Empathic Understanding in Interpersonal Processes: A Scale for Measurement

#### **Level 1**

The verbal and behavioral expressions of the helper either *do not attend to* or *detract significantly from* the verbal and behavioral expressions of the helpee(s) in that they communicate significantly less of the helpee's feelings and experiences than the helpee has communicated himself.

EXAMPLE: the helper communicates no awareness of even the most obvious, expressed surface feelings of the helpee. The helper may be bored or disinterested or simply operating from a preconceived frame of reference which totally excludes that of the helpee(s).

In summary, the helper does everything but express that he is listening, understanding, or being sensitive to even the most obvious feelings of the helpee in such a way as to detract significantly from the communications of the helpee.

#### **Level 2**

While the helper responds to the expressed feelings of the helpee(s), he does so in such a way that he *subtracts noticeable affect* from the communications of the helpee.

EXAMPLE: the helper may communicate some awareness of obvious, surface feelings of the helpee, but his communications drain off a level of the affect and distort the level of meaning. The helper may communicate his own ideas of what may be going on, but these are not congruent with the expressions of the helpee.

In summary, the helper tends to respond to other than what the helpee is expressing or indicating.

#### **Level 3**

The expressions of the helper in response to the expressions of the helpee(s) are essentially *interchangeable* with those of the helpee in that they express essentially the same affect and meaning.

EXAMPLE: The helper responds with accurate understanding of the surface feelings of the helpee but may not respond to or may misinterpret the deeper feelings.

In summary, the helper is responding so as to neither subtract from nor add to the expressions of the helpee. He does not respond accurately to how that person really feels beneath the surface feelings; but he indicates a willingness and openness to do so. Level 3 constitutes the minimal level of facilitative interpersonal functioning.

#### **Level 4**

The responses of the helper *add noticeably* to the expressions of the helpee(s) in such a way as to express feelings a level deeper than the helpee was able to express himself.

EXAMPLE: The helper communicates his understanding of the expressions of the helpee at a level deeper than they were expressed and thus enables the helpee to experience and/or express feelings he was unable to express previously.

In summary, the helper's responses add deeper feeling and meaning to the expressions of the helpee.

#### **Level 5**

The helper's responses *add significantly* to the feeling and meaning of the expressions of the helpee(s) in such a way as to accurately express feelings levels below what the helpee himself was able to express or, in the event of ongoing, deep self-explorations on the helpee's part, to be fully with him in his deepest moments.

EXAMPLE: The helper responds with accuracy to all of the helpee's deeper as well as surface feelings. He is "tuned in" on the helpee's wave length. The helper and the helpee might proceed together to explore previously unexplored areas of human existence.

In summary, the helper is responding with a full awareness of who the other person is and with a comprehensive and accurate empathic understanding of that individual's deepest feelings.

<sup>1</sup>This scale is a revision of earlier versions of empathy scales (Carkhuff, 1968; Carkhuff & Berenson, 1967; Truax & Carkhuff, 1967). (Carkhuff, 1969, vol 1, pp. 174-175)

## Appendix B

### Empathic Understanding Scale: Additional Guidelines for Coders

#### **Transcribing and Coding Guidelines**

##### **Counselor utterances.**

All counselor utterances will be coded. For the purpose of this study, an utterance is any verbal statement made by the counselor that expresses an idea (it may not be a grammatically correct sentence). Each idea will be scored separately (e.g. “Uh oh, that was hard to catch, do you want to try again” – will be scored as three separate ideas.)

Utterances are generally separated by a noticeable pause, but where it is difficult to determine a pause, err on the side of separating each idea. (e.g. “oh, that’s right,” will be recorded as: Utterance 1 - “Oh”; Utterance 2 - “that’s right”). The first idea is expressing some level of surprise, the second is stating that the child is correct. Unless there is a clear pause, don’t separate complex sentences where each idea builds on the previous. See Levels 4 and 5 for examples of ideas connected by words like “if” “because,” “and,” or “but”.

##### ***Exceptions.***

Do not code inaudible utterances if you don’t have enough information to determine the empathy level. If you cannot make out the exact sounds but have enough information to determine the level of the response, you should code it (e.g., you cannot tell if the counselor said “uhuh” or “hmm”, or “wow” or “woah”, but either is still a Level 2 response; therefore, you should code it Level 2.) Do not code gestures or any other nonverbal behaviors of the counselor.

Appendix B, Continued

Empathic Understanding Scale: Additional Guidelines for Coders

**Coding**

These guidelines were developed by the researcher in the current study to assist coders in applying Carkhuff’s empathic understanding scale ratings to play therapy and AAT counseling sessions with children. Additional guidelines and example statements were selected from the training videos with feedback from coders after they viewed and rated several sessions. Some comments were changed to be more general and to protect the privacy of the clients and counselors observed.

	<b>Carkhuff scale - Key terms and ideas</b>	<b>Additional guidelines for play therapy</b>	<b>Example client statement or behavior:</b>	<b>Example counselor response:</b>
<b>Level 1</b>	Counselor’s response: Does not attend to..., Detracts from..., or Communicates less than client expressed. Appears bored, Disinterested, or Preconceived frame of reference excludes the client.	Counselor does not respond to the child’s statements or behavior or dismisses them. Counselors attention is drawn away from the child (e.g., May be focused on a worksheet, or game rules, or the time left at the expense	“I love this game!”  “Is that a sandbox?”  Child walks in and starts hitting the bobo doll.	“There are paints over here.”  “You have 5 minutes left.”  “We have some work to do today...”  (Counselor pulls out a workbook).

<p><b>Level 1</b> <b>Cont.</b></p>	<p>Does not express listening, understanding, or sensitivity to client feelings</p>	<p>of recognizing the child’s feelings or behaviors. Counselor is talking about themselves, praising self. Counselor is talking to someone else, or to themselves. Procedural statements (how much time is left, rules for the play rooms, directions to wash hands, etc.)</p>	<p>Child passes a ball to the counselor. Counselor makes a basket.  Counselor is trying to shut the door and says aloud, but to themselves...</p>	<p>“Awesome!”          “Hmm, this doesn’t work.”</p>
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<p><b>Level 1</b> <b>Cont.</b></p>			<p>Phone call interrupts session,  Playing trouble, counselor roles and counts aloud.</p>	<p>“Hello, ……”  “One, two, three, four…”</p>
<p><b>Level 2</b></p>	<p>Some awareness of obvious surface feelings. Responds with less intensity than was expressed. Distorts the level of meaning. Counselor’s ideas are not congruent with clients expressions.</p>	<p>Counselor’s choice of words does not convey the same level of meaning as the child expressed. Counselor expresses their own feelings or ideas (e.g. shares a personal experience vs. focusing on the child’s experience), but along the same</p>	<p>“We can shoot the punch bag.”  Child scores a basket.  “This is the police man.”</p>	<p>“Good idea.” (judgment)  “Awesome!” or “Great Job!” (judgment)  “OK.” (Confirms listening but does not</p>

<p><b>Level 2</b> <b>Cont.</b></p>		<p>theme that the child brought up.</p> <p>Uses words that convey a judgment, or a vaguely indicate listening (Hmm, yeah, OK, hahaha).</p> <p>Code counselor responses to child questions about procedures, how something works, how to play a game, etc. as level 2 unless it goes beyond a direct answer to a question.</p> <p>Counselor apologizes for something they did.</p> <p>Counselor asks questions along the</p>	<p>Child sits down and says nothing.</p> <p>Child asks how something fits together.</p>	<p>reflect or go deeper).</p> <p>“What did you do last weekend?”</p> <p>(Question shows interest but is not asking about what the child is currently experiencing or feeling).</p> <p>“It goes like this.”</p>
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<p><b>Level 2</b> <b>Cont.</b></p>		<p>theme of the child’s play or conversation to probe for more information, but does NOT ask child to reflect on feelings, reasons for feelings, and is not a reflection of what the child said, phrased as a question.</p>	<p>While playing a game, Counselor throws the ball to the child, too hard, or too far away</p> <p>Child brought up the topic, but counselor probes for more information.</p>	<p>“I’m sorry”</p> <p>Why is that? Do you like Math? What is your favorite? When did that happen?</p>
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<p><b>Level 2</b> <b>Cont.</b></p>				<p>Who is that? What is that? What do you do when...?</p>
<p><b>Level 3</b></p>	<p>Responses are interchangeable with client's. Reflects back the same affect and meaning. Does not add or subtract from emotion expressed. Indicates willingness and openness. Does not respond to feelings beneath the surface, does not go deeper than what is expressed.</p>	<p>Counselor may reflect the child's actions if no emotion is expressed. Counselor may ask questions to probe for feelings, or reasons for feelings which demonstrates their interest and willingness to explore with the child Makes a verbal observation of the behavior</p>	<p>"I found the doll." "I'm good at hitting the ball right?" Child asks how something fits together. "I hate school."</p>	<p>"You found the doll." "You're good at hitting it." "You're not sure how that should fit." "What makes you think that?" (Question is related to what the child is currently</p>

<p><b>Level 3</b> <b>Cont.</b></p>			<p>Boy says, “Other kids tease me and call me names”</p> <p>Child smiles while talking.</p>	<p>expressing, shows a willingness to explore, and is asking child to reflect on a reason for a feeling).</p> <p>“How does that make you feel?”</p> <p>“You’re smiling when you talk about that.”</p>
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<p><b>Level 4</b></p>	<p>Adds deeper feeling and meaning to client’s expressions. Indicates an understanding of feelings beyond what is expressed. Allows client to experience or express feelings more deeply.</p>	<p>Emphasis is on attempting to identify <b>feelings</b>, not yet expressed. With children, the counselor may simply verbalize emotion they think is accurate based on the child’s behavior. Look for added feeling words (wants, likes/dislikes, happy, sad, angry, enjoys, pride, guilt, etc). Counselor may also attempt to identify a <b>reason</b> for a feeling the child is experiencing. It must go beyond</p>	<p>“I’m good at hitting the ball right?”  Child builds police station for second time.  Child is looking at the sun setting and wanting to go outside, “will it take a long time?” (for the sun to set)</p>	<p>“You sound like you’re <b>proud</b> of that.”  “You <b>like</b> building police stations, huh?”  “... Are you <b>worried</b> about that?” (Question labels an unexpressed feeling.</p>
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<p><b>Level 4</b> <b>Cont.</b></p>		<p>what the child has expressed. It might be a question or statement about what they are thinking, what is happening to them, or what they do that causes the feeling.</p>	<p>Child asks how something fits together</p> <p>Child is building, can't find something he wants, and uses an alternative.</p>	<p>“You seem really <b>interested</b> in solving that problem.”</p> <p>“You are finding ways around that problem.” (Identifies more than what is observed, might be a reason for feeling proud of himself).</p>
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<p><b>Level 4</b> <b>Cont.</b></p>			<p>Child is mad at someone for not letting him have a toy he wants.</p>	<p>“it sounds like you don’t agree with her.”</p>
<p><b>Level 5</b></p>	<p>Adds significantly deeper feeling and meaning to what is expressed or responds with accuracy to an expression of the clients deepest feelings.  Full awareness of the client  Comprehensive and accurate understanding of the client’s deepest feelings.</p>	<p>Emphasis is on accuracy, confirmed by client response (eg. Crying may be the client more freely allowing themselves to experience an emotion, or client may take the risk to explore deeper with the counselor).  Counselor labels a feeling and states a reason for the feeling. Both the feeling and reason have not been</p>	<p>Child is punching the bobo doll.</p>	<p>“You have a lot of <b>anger</b> today, and it looks like it just feels good to let it out.”  (Child might confirm and continue hitting, or stop and start to cry, or begin talking in a way that demonstrates more awareness or</p>

<p><b>Level 5</b> <b>Cont.</b></p>		<p>verbalized by the Participant Bet. And, the child does not deny the accuracy of the counselor’s assessment.</p>	<p>Child is acting worried about missing school for a family trip.</p>	<p>expressiveness of previously concealed feelings. Child does not deny or refute the counselor’s interpretation, indicating that it is accurate.)</p> <p>“Sounds like you’re <b>afraid</b> you’ll get <b>behind on</b> your <b>homework if</b> you miss <b>school</b>, and that’s why you’re <b>mad</b></p>
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<p><b>Level 5</b> <b>Cont.</b></p>			<p>Example with an adult from Carkhuff, 1969: -comments relate to a deteriorating home situation and the attendant distressing affect.</p>	<p>that you have to go out of town.”  (Identifies feelings and reason from child’s behaviors and descriptions).  “It’s really not home but everything, everywhere, is falling apart and it’s got you feeling pretty low, wondering about yourself.”</p>
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Appendix C

Video Coding Record

Page Number \_\_\_\_\_

Coder's Name: \_\_\_\_\_  
 \_\_\_\_\_

Session Code:

Date of Coding: \_\_\_\_\_

<p style="text-align: center;"><b>Therapist Utterances</b></p> <p>-Record each utterance on a separate line, separate when there is a noticeable pause.                      -About every 5 utterances note the time stamp so it can be easily re-located on the disc.                      -Record any changes in therapeutic setting. (E.g. Phone call, Person enters/exits room, Therapy Dog enters/exits room) and the time of each disturbance.                      ~ = inaudible utterance or part of utterance.</p>	<p style="text-align: center;"><b>Time</b> 00:00:00</p>	<p style="text-align: center;"><b>Empathic rating</b> 1-5</p> <p style="text-align: center;"><b>NR = not rated</b> (e.g. inaudible)</p>
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## Appendix D

## Curriculum Vitae

**Erin D. Perry****EDUCATION**

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Alfred University, Alfred, NY (APA accredited)	
<b>Doctor of Psychology, School Psychology</b>	August, 2017
Dissertation: <i>Counselor Empathic Responding in the Presence of a Therapy Dog</i>	
Chairperson: Jana Atlas, Ph.D.	
<b>Certificate of Advanced Study, School Psychology</b>	May, 2011
<b>Master of Arts, School Psychology</b>	May, 2009
Binghamton University, Binghamton, NY	
<b>Bachelor of Arts, Magna Cum Laude, Psychology</b>	May, 2007
Corning Community College, Corning, NY	
<b>Associate of Science, Liberal Arts</b>	May, 2005

**PROFESSIONAL CREDENTIALS**

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New York State Provisional Certificate: School Psychologist

Nationally Certified School Psychologist

**SELECT EXPERIENCE**

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The Alternative School for Math and Science, Corning, NY	
<b>Director of Student Services, 6 - 8</b>	August, 2012 – Present
Corning – Painted Post School District, Painted Post, NY	
<b>School Psychologist Consultant, Pre-K - 12</b>	November, 2011 – June 2012
<b>School Psychologist Doctoral Intern, Pre-K - 12</b>	July 2010 – June 2011
<b>School Psychology Practicum Student, Pre-K – 12</b>	August 2007 – May 2008
The Child and Family Services Center, Alfred, NY	
<b>Graduate Clinician, Advanced Practicum</b>	August 2009 – May 2010
<b>Graduate Clinician</b>	August 2008 – May 2009

**SELECT AWARDS**

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Lea R. Powell Fellowship Award, Alfred University      Fall 2007 – Spring 2008