It’s the Journey: The Developmental and Attachment Implications of Animal Assisted Play Therapy™ for Children in Emergency Housing

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DEDICATION

Vous êtes le dessin du constructeur de boa mangeant un éléphant. Incompris et oublié, tu as de grandes vérités en toi si seulement quelqu'un prenait la peine de regarder ...

[“You are the drawing of the boa constructor eating an elephant. Misunderstood and forgotten, you have great truths within you if only anyone would bother to look...”]

-Antoine de Saint-Exupéry

To all the children and families who so graciously shared their stories with me during this project: thank you for trusting me with your “great truths.”

And to Winston, the dog whose playful and earnest nature inspired this professional journey.
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It takes a village to raise a child. The same could be said of writing a dissertation.

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ABSTRACT

BACKGROUND: Child homelessness is correlated with a wide range of health and psychosocial challenges including poor school performance, juvenile justice involvement, and heightened risk of exposure to early-life violence and trauma. Despite this, participation in therapy tends to be low. Animal Assisted Play Therapy™ (AAPT), a comprehensive model that systematically integrates trained therapy animals into play therapy, serves as a compelling modality for engaging this population into treatment. The tenets of AAPT are aligned with several clinical goal areas that homeless children might address in therapy, including the strengthening of attachment relationships with primary caregivers.

METHODS: The study integrated analysis of projective drawings and accompanying narratives with the treatment records of 11 children (ages 6-11) who received canine assisted therapy while residing in an urban, mid-Atlantic family homeless shelter. All children worked with a clinician trained in AAPT and participated in at least three therapy sessions with a qualified therapy dog present. Each child created a drawing in response to the prompt: “Draw a picture of a child and a dog”, and told a story based on the contents of their drawing. Parent/caregivers of each child participated in a qualitative interview that elicited feedback and reflections on the therapy process. Grounded constructivist theory and interpretive description were used to conduct both individual and cross-participant analysis. Analysis was further informed by children’s case history files and parent interviews about children’s developmental history.

RESULTS: The projective drawings communicated aspects of homeless children’s relationships with the therapy dog and, in turn, with their primary caregivers. Developmentally, children drew at lower levels than would be expected for their age. Each child personalized their drawing, either by identifying the protagonist as their gender, or including a physical characteristic (e.g. clothing, hairstyle) unique to the child; this suggests that the children tapped into their personal experience. Several themes emerged from analysis of the drawings and narratives including representations of lived and wished-for attachment experiences. Children depicted relationships between the characters in their drawings and narratives that were characterized by emotional closeness as well as frequent separations and reunions. Children also highlighted the importance of learning tasks related to training and caring for the dogs. These themes were reflected in the children's treatment records and the parent/caregiver interviews. Parent/caregivers described their child's experience in therapy positively, and identified the therapy dog as a component of the treatment's success.

IMPLICATIONS: Projective drawings enabled homeless children to communicate their attachment experiences in a manner sensitive to their developmental needs. Themes that emerged from this study inform further research on specific benefits of animal assisted therapy. Specifically, the themes of lived and wished-for attachment experiences suggest that further research on this modality might focus on the ways that the modality allows children to build new relationships and strengthen existing ones. The drawings created during this study are a valuable tool in understanding the experiences of homeless children, and lay the groundwork for further study of the use of projective drawings for exploring children's experiences in therapy.

Keywords: Child homelessness, projective drawings, therapy dogs, play therapy, Animal Assisted Play Therapy™
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It's the Journey: The Developmental and Attachment Implications of Animal Assisted Play Therapy™ for Children in Emergency Housing

Over 2.5 million children under age eighteen are considered to be part of chronically homeless families in the United States (Bassuk, DeCandia, Beach & Berman, 2010). Included in this number are children residing in homeless shelters, children living on the streets or in cars, and children staying “doubled up” with a friend or extended family members. Child homelessness correlates with a wide range of challenges beyond a lack of stable housing. Homeless children are three times more likely to be the victim of a substantiated child abuse case, as compared to non-homeless, low-income children (Brumley, Fantuzzo, Perlman, & Zager, 2010). In school, homeless children tend to have lower grade point averages (GPA) and higher rates of absenteeism than same-aged peers (Uretsky & Stone, 2016). The combined impact of homelessness and child abuse places children at risk for decreased school performance and increased high-school dropout rate (Perlman & Fantuzzo, 2010; Uretsky & Stone, 2016). Moreover, homelessness has been identified as a leading risk factor of juvenile justice involvement (Rodriguez, 2013).

Chromically homeless children experience a range of physical and mental health challenges. Homeless mothers may lack access to health care, resulting in low utilization rates of prenatal care and high incidence of birth defects (Brumley et al., 2010). The literature suggests that homelessness is a risk factor for a range of physical health conditions including asthma, dental problems, diabetes, and sexually transmitted infections (Edidin, Ganim, Hunter, & Karnik, 2012). Estimated prevalence rates of mental disorders among homeless children range from 49 to 98%, with diagnoses of substance abuse disorders and post-traumatic stress disorders (PTSD) accounting for 40 to 68% of prevalence. Several studies also suggest heightened levels of
depression and eating disorders, as compared to same-aged peers (Hodgson, Shelton, van den Bree, & Los, 2013).

The literature on social and medical correlates of child homelessness portrays a range of adversities. Kilmer, Cook, Crusto, Strater and Haber (2012) categorize those adversities into those that precede homelessness, those associated with homelessness, and those associated with service system response to homelessness. Adversities preceding homelessness may include witnessing a domestic assault that prompted a victimized parent to leave home with the child, or experiencing a house fire that destroyed a family home. Adversities associated with homelessness might include stigma or bullying from peers, or victimization while in shelter or on the streets. Adversities associated with service system response could include local school systems failing to coordinate with service providers to meet homeless students’ needs, or shelter systems housing mothers and teenaged sons in separate shelters. That the daily lives of homeless children are characterized by minor and major adversity is consistent with the high prevalence rates of PTSD in this population.

**Homelessness and Trauma**

A potentially traumatic event is an experience that presents a real or perceived threat to one’s life or psychological wellbeing (Weathers & Keane, 2007). A potentially traumatic event might include a singular incident such as an assault, or chronic events such as years spent in, or witnessing, an abusive relationship. Trauma is a behavioral or physiological response to the potentially traumatic event, although not all individuals that experience a potentially traumatic event experience clinical levels of trauma symptomology. Post-traumatic stress disorder (PTSD) is present in approximately seven percent of the population, while an estimated two-thirds of adults have experienced a potentially traumatic event (Yehuda, 2004). Statistically, chronically
homeless children are at elevated risk for repeated exposure to potentially traumatic events including witnessing family or community violence, incarceration of a parent, and problematic drug and alcohol use by a parent (Herbers, Cutuli, Monn, Naryan, & Masten, 2014). Repeated exposure to potentially traumatic events is conceptualized as complex trauma, particularly when potentially traumatic events occur during critical developmental stages (Briere & Scott, 2015). Without treatment, children exposed to complex trauma are at increased risk for addiction, self-harming behaviors, anxiety and other psychiatric disorders (Liotta, 2013).

Homeless children tend to experience potentially traumatic events that involve physical or emotional separation from primary caregivers (Herbers et al., 2014). Attachment theory has long identified the potentially negative impact of early life separations on the ability of individuals to have meaningful social and romantic relationships in adulthood (Bowlby, 1977). Contemporary attachment theory has focused on the ways that the relational challenges faced by individuals with challenging attachment histories can impact overall functioning, including in areas of social and emotional well-being, physical health, and employment stability (Shilkret & Shilkret, 2011). Therefore, the separations homeless children face in early life might place them at risk for poor outcomes in adulthood. Consistent with this is the fact that child homelessness is a leading risk factor contributing to homelessness as an adult (Bassuk, DeCandia, Beach & Berman, 2014). Several models of child psychotherapy have been developed that enhance attachment relationships with the ultimate goal of preventing the negative outcomes for which attachment disruptions place children at risk (VanFleet, Sywulak, & Sniscak, 2010; O’Connor, 2011; Goodyear-Brown, 2010).

Children in homeless families continue to face barriers in accessing appropriate behavioral health services (Guarino & Bassuk, 2010; Bassuk, et al., 2014). Smolen (2014)
observed that homeless children develop in environments that minimally meet their physical needs and fail to acknowledge their emotional needs. Focus on physical survival and mistrust of service providers often inhibits parents’ ability to enroll a child in behavioral health services (Park, Metraux, Culhane, & Mandell, 2012). Even when homeless families do seek treatment, general mental health services are often ill-prepared to address the more complex needs of homeless families, as compared to housed families (Zlotnick, Tam & Zerger, 2010). Families’ geographical transience further detracts from the outreach efforts of behavioral health providers.

Without intervention, the impact of early-life potentially traumatic events can have lasting impact on behavior, social relationships and emotional regulation (Herbers et al., 2014). Children in chronically homeless families may be inhibited in their development of emotional framework to cope with trauma or with non-traumatic difficulties such as overcoming school anxiety. Without a well-developed emotional framework or consistent resources for coping, these children may grow into adults that struggle to maintain steady employment or social relationships (Rodriguez, Russa, & Kircher, 2015). As previously stated, child homelessness is a leading risk factor for homelessness as an adult (Cutuli, Montgomery, Evans-Chase & Culhane, 2015). This suggests that the lack of mental health treatment and resulting difficulties in coping may play a role in poor outcomes for chronically homeless children. It remains to be seen whether interventions designed to enhance coping and decrease trauma symptoms might have long term impact.

**Use of Animal Assisted Therapy**

An emerging body of literature suggests that Animal Assisted Therapy (AAT) is beneficial for individuals exposed to chronic potentially traumatic events. Preliminary evidence suggests that involving animals in psychotherapy is associated with decreased anxiety,
depression, and PTSD symptoms (O’Haire, Guérin, & Kirkham, 2015). Interaction with dogs has been shown to increase blood and urine levels of oxytocin, a neurotransmitter that modulates social behavior and physiological arousal. Higher endogenous levels of oxytocin facilitate decreased physiological symptoms of PTSD including hyper-vigilance and heightened startle response. AAT with therapy dogs has proven efficacious for military veterans with post-traumatic stress (Yount, Ritchie, Laurent, Chumley & Olmert, 2013). Because of the heightened exposure to potentially traumatic events and complex trauma, both chronically homeless children and military veterans benefit from increased oxytocin levels. Given the success of the AAT with military veterans, it is worthy to explore whether work with therapy dogs might be efficacious for others living with complex trauma histories, such as children living in emergency housing.

Under the guidance of a mental health professional, a play therapy dog acts as a nonjudgmental partner in play, guiding a child towards greater emotional regulation. The presence of a dog may afford children the capacity for developing rapport with a therapist, even if they would otherwise have difficulty engaging in treatment (Parish-Plass, 2008). Ongoing research suggests that the presence of animals enables clients to manage physiological arousal symptoms that may be triggered by entering therapy (Hunt & Chizkov, 2014). While many species can and have been integrated into therapy, the current study is focused specifically on involvement of therapy dogs. Therefore, literature reviewed in this chapter refers primarily to canine-assisted therapy.

**History and Development of Animal Assisted Play Therapy™**

VanFleet and Faa-Thompson (2015) developed a comprehensive approach that integrates play therapy and animal assisted therapy that meets the need of a theoretically and ethically sound approach to involving animals in psychotherapy. Animal Assisted Play Therapy™
(AAPT) integrates the needs and well-being of the therapy dog into the context of treatment. Clients of AAPT learn canine body language and are encouraged to identify when the therapy dog is enjoying or stressed by particular activities; in a parallel process, the client can begin to identify their own emotional cues and relay them, first to the therapist, and then generalize to caregivers (Parish-Plass, 2008). Furthermore, clients in AAPT are involved in training therapy dogs to complete tasks such as running through a tunnel or solving a puzzle toy for the purpose of bolstering the child’s sense of self-efficacy.

Offering AAPT to children in chronically homeless families represents a novel approach to treatment for a difficult-to-engage population (Flanagan & Hancock, 2010). Given that participation rates in treatment tend to be low for chronically homeless individuals, perceptions of behavioral health treatment in general, as well as specific treatment approaches such as AAPT, can provide insight into how access to and engagement in therapy might be increased (Thompson, McManus, & Voss, 2006). Based on the work of a family shelter with an onsite play therapy dog, the present study sought to address the following research questions. How do children living in emergency family housing perceive the role of an onsite play therapy dog? How are themes of children’s development and attachment reflected in these perceptions?

**Theoretical Framework**

While several theories of behavior and development provide insight into the potential clinical impact of play therapy dogs, four theories in particular add depth to the discussion. This chapter explores Margaret Mahler’s (1967) separation-individuation theory, canine domestication theory, attachment theory, and Erik Erikson’s (1982) stages of psychosocial development, and discusses how these theories can help to frame the potential impact of animal assisted therapy for children in chronically homeless families. Margaret Mahler’s theory of
psychological development centered on the separation-individuation process; contemporary interpretations of that theory are particularly salient (Mahler, Pine, & Bergman, 1975; Nachman, 1991; Gergely, 2000). Anthropological and veterinary literature on the development of the cooperative human-canine relationship provides additional insight into the evolutionary basis of mechanisms of action in canine-assisted therapy (Giffroy, 2012; Range, & Viranyi, 2015). Attachment theory bridges the gap between both bodies of literature, further supporting the notion of a therapeutic human-canine bond. Beyond the relational aspect of canine-assisted therapy, Erikson’s (1982) psychosocial stages of development inform analysis of the modality’s impact on children of the school age.

**Separation-Individuation Theory: Margaret Mahler**

Margaret Mahler conceptualized early psychological development as an unfolding process in which the infant develops an autonomous sense of self. In stages, the infant gains a sense of him or herself as a being separate from the primary love object, traditionally the mother (Mahler, Pine, & Bergman, 1975). From birth, infants experience what Mahler coined the *normal autistic phase*; infants spend most of their time sleeping, and awake to fulfill physiological needs such as hunger and elimination. The infant’s waking hours are devoted to the fulfillment of these needs. According to this framework, the infant does not perceive the primary love object as responding to his or her cry to fulfill hunger needs; he or she only perceives the hunger need as being fulfilled. To the infant, this primary love object fulfilling the infant’s hunger need is indistinguishable from the infant-controlled release of tension through urination or defecation. In Mahler’s model, an infant in this stage perceives waking hours as times of physiological tension and subsequent release of that tension, without a concept of how tension is released. The infant’s perceptual experience is similar to that within the womb, as there is minimal awareness of
external stimuli (Mahler, Pine, & Bergman, 1975).

Dim awareness of the primary love object emerges at two months old, the onset of the symbiotic phase, yet the infant does not fully perceive the primary love object as separate from the self. Infant and love object enter a symbiotic orbit, with a perceived barrier existing between the rest of the world and the infant-love object dyad. Mahler conceptualized infants at this stage of having increasing awareness of the distinction between internal and external experiences. Through this symbiotic phase, the primary love object is described as a “part-object” who the infant perceived as part of him or herself and also simultaneously responsible for gratifying the infant’s physiological needs (Mahler, Pine, & Bergman, 1975, p. 49). Mahler observed that breastfeeding was a fairly straightforward example of the symbiotic orbit, but was not the only form of symbiosis. Other examples might include holding an infant close, or speaking warmly to an infant. Infant behavior indicative of the love object as separate, such as smiling directly at a parent, signals the end of the symbiotic phase.

Separation-individuation, the process of an infant understanding the primary love object as a separate being, begins at five months of age. The infant’s sensory and perceptual systems develop rapidly during this process, and the infant grows to understand his or her role as an individual being and as separate from external sensory stimuli. The primary love object transitions into a new role as a mediating partner, a separate entity actively engaged with the infant in the development of a sense of self (Brandell, 2010). Progression through separation-individuation occurs in phases, and each phase is associated with developmental milestones, summarized in the table below (Mahler, Pine, & Bergman, 1975).

In Mahler’s framework, the separation-individuation process informs adult development of self-esteem and individuality. During separation-individuation, the physical and emotional
IT’S THE JOURNEY

presence of a primary caregiver provides children with a secure base from which to explore the world. Through exploration and play, the child seeks independence and mastery of the environment while still prioritizing the bond with the primary caregiver. A child in a parent-infant playgroup may gain confidence from choosing toys to play with and learning how the toys work. Sharing the toy with an emotionally present, responsive caregiver can further reinforce this confidence while strengthening the attachment with the caregiver. This dialectic relationship continues until the onset of the *rapprochement* crisis (Mahler, Pine, & Bergman, 1975).

<table>
<thead>
<tr>
<th>Stage</th>
<th>Age (in months)</th>
<th>Developmental Milestones</th>
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| Hatching Phase     | 5 to 9          | • Becoming aware of individuality  
                          • Smiling directly at love object  
                          • Exploring surroundings with attachment figure as reference point |
| Practicing Phase   | 9 to 17         | • Continuing to perceive attachment figure as part of the self  
                          • Actively and independently exploring surroundings; learning to crawl and walk |
| Rapprochement Crisis | 18 to 36       | • Realizing that physical separateness equals psychic separateness  
                          • Learning to walk  
                          • Continuing to explore surroundings; tentative regarding leaving attachment figure’s presence |

*Table 1. Phases of Mahler’s Separation-Individuation theory*

**Significance of Rapprochement.** Within Mahler’s framework, the period of time between 18 and 36 months, the *rapprochement crisis*, holds great developmental significance. In this developmental stage, the child fully comes to understand the primary caregiver as a separate entity. This shift occurs in three sequential stages, and is summarized in Table 2.

<table>
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<th>Sub-Stage</th>
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<td>Beginning</td>
<td>Child motivated to share discoveries with caregiver</td>
</tr>
<tr>
<td>Crisis</td>
<td>Child’s motivation to explore surroundings at odds with motivation to stay close to the caregiver</td>
</tr>
<tr>
<td>Solution</td>
<td>Child comes to understand separateness from caregiver as reality</td>
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*Table 2. Sub-phases of rapprochement in Mahler’s Separation-Individuation theory*

In understanding individuation on a cognitive level, children also experience the emotional
impact of separation-individuation (Mahler, Pine, & Bergman, 1975).

Children at this age may appear to regress emotionally: clinging to their parents in situations wherein they previously exhibited independence. Mahler and her colleagues (1975) described two classic behaviors occurring at the onset of rapprochement—shadowing, maintaining close physical proximity to the primary love object; and darting away, physically detaching from the primary love object. These patterns of physical interactions with the primary love object mirror the child’s cognitive processing of themself and the love object as separate beings. Behaviorally, a child may exhibit increased separation anxiety or increased emotional outbursts. If a caregiver approaches rapprochement crisis behavior with calm and supportive presence, the child learns that negative emotional states can be managed. This lays groundwork for the child to develop techniques for coping with difficult emotional states. Without a resolution of the rapprochement crisis, a child may grow into an adult who has not learned to self-soothe. Failure to develop this ability can have detrimental effects on an individual’s ability to self-regulate in adulthood; this bares negative implications for one’s sense of individuality and self-esteem (McDevitt, 1991).

**Contemporary Critique of Separation-Individuation.** Mahler’s (1967) separation-individuation theory has heavily informed psychoanalytic understanding of early childhood development. In turn, ongoing research provides insight on some limitations in the theory. After her initial writing, Mahler continued to study early child development, and amended her conceptualization of the first months of life. Moreover, contemporary critique of Mahler’s work has focused on the generalizability of the theory beyond the Western, hetero-normative society in which it was developed.

**Normal Autistic Phase.** One of the most common criticisms of the separation-
individuation process is the underlying assumption that a barrier prevents early-stage infants from recognizing any external stimuli (Coates, 2004). Further studies of infancy, including those conducted by Mahler’s lab, identified an emergent capacity for early-stage infants to distinguish between stimuli. One powerful example of this recognition is the difference in behavioral response to a caregiver’s, as opposed to a stranger’s, voice (Gergely, 2000). Mahler amended her developmental theory to largely exclude the normal autistic phase; contemporary adherents to Mahler often omit the normal autistic phase entirely from descriptions of the separation-individuation process (Higgins-Klein, 2013).

_Cultural Bias._ The notion of separation-individuation as an indicator of psychological health is rooted in Western, and particularly American, cultural values. The focus on independence and autonomy may not reflect the cultural values and developmental goals of a non-Western society. Some evidence suggests that the very definition of autonomy may be dependent on socially constructed norms and cultural values; where Western cultures equate autonomy with separation and independence, Eastern cultures might view the ability to contribute financially or to the community as a demonstration of autonomy (Olsen, Yang, Robinson, Wu, Nelson, Nelson et al., 2002). Therefore, in these cultures, behaviors promoting Mahler’s notions of autonomy may not be supported or encouraged by parents and caregivers (Iyengar & DeVoe, 2003). If the separation-individuation process is not reinforced by caregivers and the broader cultural context, a child’s progression through this process represents a poor indicator of psychological growth. In applying Mahler’s separation-individuation framework to assess psychological growth in research, one must consider the cultural values of the population of interest.

_Contemporary Gender Roles._ In its original form, separation-individuation theory values
the mother-child relationship as a catalyst for psychological growth (Mahler, Pine, & Bergman, 1975). While parenting behaviors promoted in Mahler’s original writing such as emotional availability and are valued in contemporary child development literature, fathers and other caregivers might also display these behaviors. As women have increased participation in the workforce, they have become less likely to be the sole caregiver for their children; two-parent, heterosexual couples have experienced shift in the division of labor with regards to parenting (Kaufman & Uhlenberg, 2000). In contemporary American society, fathers have shifted from being solely in the role of a financial provider and have begun to take a more active caregiving role. For example, fathers have begun incorporating their children into their leisure time at significantly higher rates than fathers one generation ago (McGill, 2014). Mahler’s original writing does not discuss the role of parents outside of a two-parent, heterosexual family. According to the 2010 Census, 63% of children lived in households with two-parents, and 16% percent of two-parent households were headed by same-sex couples (Vespa, Lewis, & Kreider, 2013). When applying Mahler’s framework to contemporary family dynamics, it is important to consider that the term “love object” could be applied to a wide range of caregivers and parental figures.

Despite contemporary critique of separation-individuation, the theory continues to provide insight into psychoanalytic understanding of early child development. As one of the first theoretical models to integrate infant research into its framework, separation-individuation is a precursor to neurodevelopmental research on infant development (Gergely, 2000). Primarily based on infant observation, separation-individuation research first documented and conceptualized the behavior of shadowing and darting away as a behavioral representative of a cognitive process. For children in homeless families, the relational components of Mahler’s
theory help to contextualize the significance of early-life separations in human development.

Smolen’s (2003) case studies of chronically homeless children indicate that these children are likely to have endured physical or emotional separations from their mothers during the rapprochement crisis. This is consistent with the more recent finding that the most commonly experienced potentially traumatic events in this population are witnessing domestic violence, having an incarcerated parent, and becoming permanently separated from a parent (Herbers et al., 2014). Each of these experiences represents or places the child at risk for a prolonged separation from a parental figure. While the mothers described in Smolen’s (2003) case studies went to great lengths to ensure their children’s physical survival, resources do not always exist to meet the emotional needs of homeless children. For example, Smolen (2003) described these children as “being rarely held” (p. 250). This is further compounded by the mothers’ own childhood histories of trauma. Without the patient presence of a parent whose basic survival needs are met, children may struggle to gain the ability to self soothe (Gallacher, 2006). As result, children may express difficult emotions externally; depending on developmental level, this could manifest as behavioral acting out, substance abuse or interpersonal violence (Rodriguez, 2013).

Separation-individuation also highlights the potential developmental importance of a therapy dog. In AAPT, the therapy dog can play the role of mediating partner, a core developmental role in Mahler’s theory, and aid the child in enhancing the ability to self soothe (Mahler, Pine, & Bergman, 1975). Common games that children play with dogs include fetch, in which a child throws a ball and the dog runs to retrieve the ball; and tug-of-war, in which the dog and child pull opposite ends of a rope until one player lets go of the rope. Like the rapprochement-age behaviors of shadowing and darting away, games of fetch and tug-of-war
allow children to test the limits of their bond with a dog in a structured, playful manner. In initiating a game of fetch, a child implicitly asks of the dog, “will you return to me if I send you away?” In tug-of-war, the child asks, “will you still love me even if we quarrel?” These questions are central to the developmental tasks of the separation-individuation framework; as a child explores these questions through AAPT, he or she gains insight, through a parallel process, into how their primary love object might respond to these questions.

**Domestication Theory: Canine Cooperation Hypothesis**

The study of animal assisted therapy (AAT) requires consideration of the contextual bases for the relationship between humans and the non-human animal involved in therapy. The onset of the canine-human relationship is recognized as occurring 5000 years prior to domestication of other animals, such as horses and livestock (Giffroy, 2012). The earliest archeological evidence suggests that modern day dogs (*Canus lupus familiaris*) originated as wolves, and were domesticated at the end of the last Ice Age, approximately 15,000 BP (Clutton-Brock, 2002). Canine cooperation hypothesis posits that at this time, ancestral wolves that posed no threat to humanity were not hunted, and in turn were likely to be provided with food and shelter (Range & Viranyi, 2015). Co-habitation continued for millennia, and descendants of these wolves evolved into the modern-day dog (Serpell, 2002).

According to canine cooperation hypothesis, the most tolerant and cooperative of ancestral wolves were most suitable for domestication. This group of wolves was distinct from those that evolved into contemporary wolves (*Canus lupus lupus*). One interpretation of this is that domesticated dogs’ playful, cooperative nature is a product of evolution (Range & Viranyi, 2015). Canine cooperation hypothesis also acknowledges the survival role that cohabitation with humankind played in the evolution of domesticated dogs. Genetically, this cohabitation put
selective pressure on the ancestors of modern day dogs to exhibit traits such as agreeableness, tolerance and loyalty. In turn, dogs exhibiting these traits were favored in contemporary selective breeding practices (American Veterinary Society of Animal Behavior, 2008). Dogs, therefore, are the current manifestation of a species of wolves that has evolved with humans in a convergent fashion.

While many theories of domestication exist, canine cooperation hypothesis is aligned with current findings and best practices in genomics, anthropology, and animal behavior. Genetic differences between *Canus lupus lupus* and *Canus lupus familiaris* have been known for several decades. For example, there are systematic differences in the ways that dogs and wolves solve puzzle tasks in a controlled experimental setting. Previously, this had been attributed to genetic differences in cognition and problem solving (Frank & Frank, 1985). Genome analyses of contemporary wolves and domesticated dogs identified alleles under positive selection during domestication. Examples include genes associated with digestion and metabolism, and some neurological processes. Many of these variants correlate with genes positively selected in humans (Wang et al., 2013). These analyses suggest a genetic basis for demographic changes occurring in both humans and canines during domestication, and that these changes facilitated the human-canine bond. For example, dogs have evolved to respond to human’s visual and oral cues (Giffroy, 2012). This enhances the ability of dogs to communicate with humans and, in turn, respond to behavioral principles in training (Pryor, 2002).

**Relevance for Canine-Assisted Therapy.** In AAPT, therapists support clients in building positive and trusting relationships with therapy animals (VanFleet & Faa-Thompson, 2017; Parish-Plass, 2008). There is a genetic basis for humans’ capacity for bonding with dogs, and domesticated dogs are dependent on humanity to meet their own current survival needs
(Walsh, 2009). In AAPT with canines, two species that have co-evolved for survival purposes share in the therapeutic interaction. Dogs are genetically primed to respond to human cues, and therefore can learn to participate in activities directed by a therapist trained in this modality and, in turn, a child who receives therapy. The cooperative nature of modern day dogs, selected by an evolutionary process, facilitates their participation in therapy.

Children’s responses to therapy dogs are preceded by a long history of humans’ tendency to form relationships with non-human animals. Shipman (2010) coined the term for this tendency, “The Animal Connection,” and described this as a defining characteristic of humankind. Anthropological evidence for the importance of “The Animal Connection” includes domesticated animals being the subject of cave-paintings, humanity’s earliest example of symbolic representation; and the similarity between rudimentary hunting tools and the teeth and fangs of ancestral wolves. The latter has been suggested as evidence that human’s relationship with wolves served as a catalyst for learning to hunt, underscoring the survival role that the relationship has played in the species’ history (Shipman, 2010; Serpell, 2002). Human investment in the relationship with canines has developed over millennia and facilitates engagement in interventions involving therapy dogs.

**Attachment**

Theories of separation-individuation in the human infant, and of the historical evolution of the human-canine bond, speak to the importance of attachment in mammalian species. Bowlby (1977) identified that the nature of early interactions with a primary caregiver, usually the mother, impacts later social and emotional functioning. A secure attachment with a caregiver, operationalized as both predictable and nurturing, provides an infant with a secure base from which to explore the world (Shilkret & Shilkret, 2011). Without this base, children, and later
adults, struggle to find safety within in the social and emotional realm.

Attachment theory considers the desire for physical closeness to be hardwired and critical for survival; an infant depends on constant touch and nurture to have his or her basic survival needs met. Infants whose needs are not met in the early years often develop insecure or anxious attachment, characterized in early childhood by either resistance in separation from the primary caregiver, or apparent ignoring of the caregiver’s physical departures and returns (Brandell, 2010). Both insecure and anxious attachments are recognized as relational styles developed to cope with the physical or emotional absence of a primary caregiver (Shilkret & Shilkret, 2011). In later childhood and adulthood, individuals with an insecure or anxious attachment style report lower satisfaction in relationships and score lower on subjective measures of well-being (Milyavskaya & Lydon, 2013). These results suggest that the development and evolution of secure attachment has significant implications for one’s psychosocial health and overall functioning.

**Attachment and homeless children.** For chronically homeless children, traumatic exposure and disrupted early attachment experiences contribute to a compromised sense of safety (Smolen, 2014). Homeless parents face numerous challenges including limited social support, histories of trauma and abuse, and practical concerns about survival needs (Meadows-Oliver, 2016; Roschelle, 2017). The realities of homelessness inhibit parents’ abilities to regulate their own emotions and foster child autonomy, core tasks of parenting that facilitate development of secure attachment bonds (David, Gelberg, & Suchman, 2012). Furthermore, homeless mothers experience major depressive disorder at disproportionally high rates; maternal depression represents a significant risk factor for a child’s insecure or disorganized attachment style (Bassuk & Beardslee, 2014). If a child lacks stability or predictability in their relationship with a primary
caregiver, this presents a challenge to the child’s ability to later form stable and predictable relationships with peers and romantic partners. Attachment security can be developed and enhanced through psychotherapeutic intervention; play therapy that involves parents or other primary caregivers supports this development in a safe and nurturing environment (VanFleet, Sywulak, & Sniscak, 2010; O’Connor, 2011; Goodyear-Brown, 2010). Introduction of a therapy dog into work with this population has the potential for further fostering emotional safety in treatment.

**Attachment and companion animal relationships.** The American Veterinary Society of Animal Behavior (2008) has formally renounced the notion that dominance over one’s animal and associated aversive training methods such as shock collars and choke chains are best practices. Contemporary dog training has embraced methods of positive reinforcement such as shaping and marker training (Pryor, 2002). Proponents of positive dog training operate under the assumption that learning is most effective when humans set clear limits and consistently reinforce positive behavior with treats, praise, or affection (Yin, 2007). There is a relational component to this training approach; for praise and affection to be effective reinforcement, the dog must have a positive association with the human providing the praise and affection.

Jalongo (2015) wrote about the connection between the parent-child bond and the child-dog bond, noting that each relationship is characterized by proximity seeking, expectation of protection, and resisting separation. The contextual basis of the human-canine bond can be understood through the canine cooperation hypothesis; the contextual basis of the parent-child bond can be understood through separation-individuation. The common mechanism of attachment allows for parallel processes of attachment formation and repair to occur for the child in therapy and with the primary caregiver. The relationship that the child and caregiver form with
the therapy dog can model enhanced security in the parent-child attachment bond.

**Psychosocial Development: Erik Erikson**

Erik Erikson authored a psychoanalytically informed developmental framework comprised of eight sequential stages (Table 3), each representing a core conflict to be resolved (Erikson, 1982). In each stage, individuals confront the conflict and must learn to respond to both sides of the dichotomy and manage the tension between the two. For example, in infancy, individuals grapple with the conflict of trust versus mistrust; successful resolution of this phase would include learning to identify feelings of trust and developing a response to feelings of mistrust. If the conflict is resolved successfully, individuals develop age-appropriate wisdom, sometimes called a virtue that enhances one’s ability to confront future stage’s conflicts. Resolution of the infancy stage conflict of trust versus mistrust is hope. Hope enables the infant to face future conflicts armed with an implicit understanding that a positive outcome is possible. This underscores the importance of the sequential nature of the framework.

<table>
<thead>
<tr>
<th>Name of Stage</th>
<th>Psychosocial Conflict</th>
<th>Approximate Age</th>
<th>Virtue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infancy</td>
<td>Trust vs. Mistrust</td>
<td>0-18 months</td>
<td>Hope</td>
</tr>
<tr>
<td>Early Childhood</td>
<td>Autonomy vs. Shame/Doubt</td>
<td>2-4 years</td>
<td>Will</td>
</tr>
<tr>
<td>Play Age</td>
<td>Initiative vs. Guilt</td>
<td>4-5 years</td>
<td>Purpose</td>
</tr>
<tr>
<td>School Age</td>
<td>Industry vs. Inferiority</td>
<td>5-12 years</td>
<td>Competence</td>
</tr>
<tr>
<td>Adolescence</td>
<td>Identity vs. Role Confusion</td>
<td>13-19 years</td>
<td>Fidelity</td>
</tr>
<tr>
<td>Young Adulthood</td>
<td>Intimacy vs. Isolation</td>
<td>20-39 years</td>
<td>Love</td>
</tr>
<tr>
<td>Adulthood</td>
<td>Generativity vs. Stagnation</td>
<td>40-64 death</td>
<td>Care</td>
</tr>
<tr>
<td>Old Age</td>
<td>Ego Integrity vs. Despair</td>
<td>65-death</td>
<td>Wisdom</td>
</tr>
</tbody>
</table>

*Table 3. Erik Erikson’s stages of psychosocial development*

It is important to note that, in Erikson’s (1982) framework individuals do not become “stuck” in an earlier life stage if they lack resolution to that stage’s conflict. Rather, individuals
approach the subsequent stage deficient in managing the tension between the two sides of the conflict. Contemporary scholarship on Eriksonian theory suggests the presence of a general factor of psychosocial development that enables individuals to resolve life-stage conflicts successfully. Similar to a measure of overall intelligence, a general factor of psychosocial development taps into a singular characteristic that correlates with success across (Jensen, 1998; Spearman, 1904). In a meta-analysis of 50 different samples ($N = 20,362$), sixty-two correlational matrices were run among indicators of life-stage conflict resolution within and between stages. Positive correlations within each life-stage ($r = .76$) and among life-stage indicators ($r = .58$) were found (Dunkel & Harbke, 2017). Results of this study suggest an interconnectedness among the life-stage conflicts; clinically, this finding implies that enhancement of one’s ability to resolve one conflict prepares one to resolve future life-stage conflicts and enables one to develop new approaches to confront prior, unresolved conflict.

**Focus on School-Aged Conflict.** The sampling frame for this study included children ages five to eighteen years, but the majority of children eligibility criteria were between six and eleven years old. This age-range represents the school-aged stage, in which individuals face the conflict of experiences of industry versus feelings of inferiority (Erikson, 1982). Children in this pre-pubescent stage begin to notice aptitudes of their peers, and compare their own competencies to that of their classmates. Successful resolution of this conflict requires that children have ample opportunity to explore their surroundings, attempt to master new skills, and learn from mistakes made in this process. Furthermore, children must also have sufficient social and emotional support to maintain levels of self-esteem necessary to engage in attempts at exploration and mastery (Bantra, 2013). In Erikson’s (1982) framework, the virtue that individuals strive for during this life-stage conflict is competence. The challenge of clinicians and other helping
professionals working with this age group is to support children emotionally while challenging them to grow in confidence and competence.

**Relevance in Traumatized Populations.** Trauma-focused psychotherapeutic interventions recognize the importance of gaining feelings of competence through the healing process (Goodyear-Brown, 2010; Hyland, Maguire, Shevlin, & Boduszek, 2014). When a child experiences interpersonal trauma, their innate sense of safety, and expectation of predictability are challenged. Children may express post-traumatic symptoms in the form of excessive worry, avoidance of reminders of the trauma, difficulty sleeping, and exaggerated startle response (Rodriguez, Steinberg, & Pynoos, 1999; King, Solomon, & Ford, 2016). These symptoms inhibit children’s ability to comfortably approach new tasks, and their feelings of security when they are not successful in completing those new tasks, thus hindering development of self-efficacy or competence (Liotta, 2013). Without intervention, children’s symptoms persist and can proliferate into behavioral acting out. Children may seek self-efficacy through destructive means, such as fire-setting or aggression against peers (Weathers & Keane, 2007). Treatment that includes an expressive component allows children to gain competence and self-efficacy through productive means. Children might enact themes of their trauma through play, writing, art, or other forms of creative expression (Gil, 2010).

**Relevance for AAPT.** A major component of the AAPT framework is the client’s development of skills related to the care and training of therapy animals. The specific components of an AAPT intervention will depend on the specific therapist and clinical goals. However, AAPT clients participating in AAPT with canines, for example, will learn at least the basic principles of dog training, and gain some proficiency in recognizing dog body language (VanFleet & Faa-Thompson, 2017). Some clients may become more involved in the training
process, even selecting a new cue for the dog to learn and working with the dog over the course of several weeks to teach the dog this cue (VanFleet, 2008). This process contributes to a sense of competence, and empowers clients to regain self-efficacy in areas of their life that they have avoided. The certification process for AAPT requires clinicians to demonstrate proficiency not only in incorporating a therapy dog into clinical work, but also in reading and responding to the dog’s non-verbal communication (International Institute for Animal Assisted Play Therapy™ [IIAAPT], 2016). Modeling competent practice with animals, and empowering clients to develop new competencies, provides clients with tools to gain mastery over post-traumatic symptoms.

**Literature Review**

Accuracy in reporting of rates of child homelessness is hindered by the varying definitions of the word ‘homeless’. Homelessness can be characterized as living on the streets, residing in a shelter or even ‘doubling up’ and staying at a friend or family member’s home. The common bond between these experiences is the lack of a stable and consistent housing arrangement. In a national report on child homelessness, Bassuk, DeCandia, Beach, and Berman (2014) totaled the children in the previously discussed living situations to be 2.5 million. The authors noted that the accuracy of this estimate depends on the efficacy of measurement methods. One such method is the point-in-time count, a quarterly count of all sheltered individuals and those living on the streets. A group of volunteers systematically conduct outreach and take census of individuals sleeping outside on one night.

Bassuk and colleagues (2014) note that, because the point-in-time count does not occur in all cities, consistency of the report may vary by state. However, the scope of child homelessness in the population of interest may be best represented by the PIT count for the City of Philadelphia. In the January 2014 PIT count, a reported 1,604 individuals occupied family
emergency shelter beds on a single day; there were a total of 939 families in emergency shelter or transitional housing. The majority of individuals residing in family emergency shelters, almost 60%, were children under the age of 18 (Henry, Cortes, Shivji, & Buck, 2014).

**Challenges associated with homelessness.** Herbers, Cutuli, Monn, Naryan and Masten (2014) examined the life experiences of children ages 4 to 6-years-old (N= 138) living in emergency family housing. In an effort to conceptualize the scope of traumatic exposure and other risk factors for poor health outcomes, the authors administered a series of cognitive assessments and parent interviews. Among this sample, the average number of reported potentially traumatic events was 3.05, with a maximum of 10 potentially traumatic events, according to parent report. The most common potentially traumatic events reported were witnessing domestic violence (34.8%), having an incarcerated parent (32.6%) and experiencing permanent separation from a parent (29.7%). A significant portion of the sample (28%) endorsed clinical levels of posttraumatic stress symptoms, based on parent responses to an informal PTSD screening questionnaire. The authors compared the results of the screening to results of standardized IQ tests and observations of executive functioning tasks and parent-child interactions. Adversity, defined here as a total of at least 3 potentially traumatic events, was moderately correlated with developing posttraumatic stress symptoms (r = .3), with the effect enhanced (r=.42) by the absence of Positive Co-Regulation. Positive Co-Regulation was defined as an observed pattern of reciprocal emotional responsiveness during parent and child interactive tasks; independent observers (inter-rater reliability = 0.85- 0.96) coded parent-child behaviors as either actively engaged, withdrawn or signaling/bidding. If withdrawn parent-child engagement can increase the impact of potentially traumatic events, active parent engagement may act as a protective factor against development of posttraumatic symptoms.
Herbers and colleagues’ (2014) study suggests that while homeless children are at significantly high risk for traumatic exposure and enhanced risk for ultimate development of posttraumatic stress, strong ties to family might be a protective factor. Families living in shelter, as opposed to those staying “doubled up” with extended family members, may lack the social support that might have served as a safety net (Bassuk, DeCandia, Beach, & Berman, 2014). This could speak to a greater incidence of psychiatric distress and a more robust need for mental health services. Zlotnick, Tam and Zerger (2012) conducted a meta-analysis of intervention studies (N=43) specifically targeting children in the shelter system and the comparable, transient population of children in the foster care system. The authors conducted a search of several major databases for peer reviewed English-language articles spanning the years 1993 through 2009. Only three studies identified a behavioral health intervention specifically targeting homeless youth; the majority of studies broadly targeted children exposed to a series of potentially traumatic events. Of the studies included, most interventions were brief in nature and directly focused on the reduction of problem behaviors, rather than addressing trauma or attachment experiences. Specific interventions included Parent Child Interaction Therapy, family-based intensive treatment and psychoeducational parenting groups.

Zlotnick et al.’s (2012) meta-analysis acknowledged that the targeted problem behaviors, including truancy and aggression, were likely the result of underlying trauma symptoms. However, few of the studies (N=2) highlighted interventions geared towards treating or preventing posttraumatic stress. Several of the studied lacked an adequate comparison group; 29% of the studies compared their intervention to supportive counseling, and found varying levels of effectiveness. In their discussion of practice implications, the authors theorized that the availability of treatment is reflective of challenges inherent in working with children exposed to
chronic potentially traumatic events who also lack predictable and stable housing arrangements, and are thus hard to track. This study highlights that therapeutic services are rarely a component of care planning for homeless services. Families may be focused on securing stable housing and accessing food and other tangible goods. Behavioral health service referrals may be provided, but families struggling to meet basic survival needs may not be physically and emotionally able to access these services.

Some literature suggests that the experience of homelessness is positively correlated with juvenile justice involvement. For example, in a larger study of involvement in multiple systems across African American youth, Warf, Clark, Herz and Rabinovitz (2009) found that children with a history of living in shelters were three-times more likely than same-aged peers to be incarcerated by the age of eighteen. Furthermore, the experience of foster care is associated with an increased likelihood of incarceration. The authors of this study conjectured that childhood involvement in social systems sets up a developmental trajectory that fosters continued use of social systems throughout adolescence and adulthood. A child who experiences homelessness or foster care grows into an adolescent who becomes involved in the juvenile justice system; as an adult, this child is more likely to be incarcerated or homeless. The results of this study suggest that the behavioral outcomes of youth in shelter can negatively impact adult life trajectory, and that dependence on social systems can persist through the life course.

**Attachment needs in homeless families.** Case studies of children provide insight into the daily experiences of homeless children and families. Smolen (2003), a clinician working with children in emergency housing, wrote a conceptual paper based on case studies of children she treated. She wrote that these children often experienced a series of traumatic events, resulting in compromised attachment bonds, beginning at or around the time of birth. She characterized these
children as being “rarely held” because their mothers were focused on “searching for a place to sleep for the night and concentrating on finding their next meal” (Smolen, 2003, p. 250). In her discussion, she drew connections between the deprivation of touch and the behavioral and emotional struggles of these children. In later work, Smolen (2014) identified unmet attachment needs, including the lack of physical closeness, as driving forces behind intergenerational transmission of emotional neglect and, subsequently, homelessness. When survival needs take precedence over the intertwined concepts of physical contact and emotional closeness, children struggle behaviorally in response. Through psychoanalytically informed therapy, the mother-child dyads with which Smolen (2014) worked began to develop new frameworks for relating to each other and to their peers. Smolen’s (2003, 2014) work suggests that although family homelessness is correlated with compromised attachment experiences, a trusting relationship with a psychotherapist can empower families to redefine levels of trust and comfort within their own relationships.

The developmental impact of touch is well documented in the literature. Ardiel and Rankin (2010) contend that multisensory stimulation is necessary on a cellular level for the physical and cognitive development of many organisms. In mammalian species, rats serve as a salient animal model for this principle. In a controlled study, rat pups who were licked less frequently (SD >1) showed significantly slower rates of maze completion and other problem-solving tasks, as compared to rat pups that were licked more frequently. This study identified maternal licking and grooming as analogous to maternal cuddling and holding among primates. Rats are commonly used as biological models for human physiology. The authors argue that the results suggest enhanced physical affection can have long-lasting impact on cognitive and behavioral outcomes in rats, and similarly, humans. In attachment theory, appropriate physical
closeness is an important component of the trusting relationship that infants build with their primary caregivers (Bowlby, 1997; Shilkret & Shilkret, 2011). Infants come to associate safe physical contact with the fulfillment of caregiving needs, an association that persists throughout the lifespan. Extrapolating the findings from Ardel and Rankin (2010)’s study of rats, it can be understood that physical touch is not only essential to children’s feelings of safety, but also to cognitive development. Enhanced capacity for safe physical touch could be a goal of therapy but must be considered from an ethical standpoint.

Contemporary play therapists acknowledge the potential therapeutic nature of safe and nurturing physical contact (Association for Play Therapy [APT], n.d). For example, an otherwise anxious child may feel security leaning against a therapist reading a story. In the code of ethics of the APT, there are guidelines for maintaining professional boundaries in light of the therapeutic nature of touch. Generally speaking, clinicians should model appropriate boundaries when children seek physical contact. A therapy dog, however, could engage in physical contact devoid of human context; a therapy dog can snuggle on a client’s lap or lick the client’s face, behaviors that would be completely inappropriate for human therapists to engage in. The literature on AAT considers appropriate physical contact to be a benefit of the modality (Zilcha-Mano, Mikulincer & Shaver, 2011). A child with a physical or sexual abuse history, for example, might find the safe touch of a therapy dog to be intermediary step towards hugging a parent (VanFleet & Faa-Thompson, 2015).

**Unmet need for behavioral health services.** An estimated forty-seven percent of homeless children meet criteria for a mental health diagnosis, yet participation rates in therapy tend to be low (Brumley et al., 2010; Park, Metraux, Culhane, & Mandell, 2012). Consistent with research on other traumatized populations, “no show” rates in therapy sessions tend to be
high; some studies estimate rates to be as high as fifty-percent (Thompson, McManus, & Voss, 2006). Despite the identification of relationships between trauma and poor therapy attendance in the literature, for many provider agencies, frequent absences may result in cancellation of services. Transience among homeless families may further contribute to low participation rates. Even if families seek therapy, difficulty finding transportation to appointments might preclude a family from participation, and frequent changes in contact information might result in a family ending therapy prematurely due to the therapy program being unable to contact them (Brumley et al., 2010). Several studies have attempted to test specific hypotheses regarding homeless families’ low participation rates in therapy.

Research indicates that homeless children are significantly less likely than low-income, housed peers to enroll in ongoing psychotherapy programs. Park, Metraux, Culhane, and Mandell (2012) reviewed Medicaid records in a major mid-Atlantic city between the years of 1998 and 2004 to determine behavioral health utilization rates among children in low-income families and, more specifically, whether those rates were impacted by housing status. Among Medicaid-eligible children with a behavioral health diagnosis, about five percent sought inpatient services and about twenty percent sought outpatient services over the course of the study. As compared to the other Medicaid-eligible children, homeless children consistently participated in both inpatient and outpatient treatment at rates that were two to five percent below average. The results of this study suggest that while the financial challenges associated with Medicaid-eligibility present barriers against accessing mental health treatment, the experience of homelessness further compounds these barriers.

Several financial and pragmatic barriers exist for homeless families seeking therapy. Yet, studies on services provided within the shelter environment also report high drop-out rates. In a
pilot study of a shelter-based mental health screening and referral program in a major Southern metropolitan area, only 50 of the 118 children who enrolled in the study participating in their screening appointment. Of those 50, 25 children ultimately scheduled and attended an initial psychotherapy appointment (Lynch, Wood, Livingood, Smotherman, Goldhagan, & Wood, 2015). While some attrition was due to families leaving the shelter prior to their scheduled appointment time, this only accounted for 10% of these cancellations. The results of this study suggest that barriers to treatment exist that simply offering services in-shelter will not alleviate. This bears implications for the current study, which sought to understand the impact of an experiential treatment modality within the context of a shelter. In sum, the limitations of offering behavioral health services to homeless populations could be counteracted by a modality like AAPT.

**Animal Assisted Play Therapy™**

A playful, engaging modality that enhances a child’s capacity for secure attachment could serve as an effective intervention for homeless children at risk for posttraumatic stress. Previous studies have established that children living in emergency housing are likely to experience a series of potentially traumatic events, and are unlikely to have access to behavioral health services to specifically address posttraumatic symptoms (Guarino & Bassuk, 2010; Bassuk, DeCandia, Beach & Berman, 2014). Furthermore, even when treatment is available, participation in mental health services tends to be low among chronically homeless individuals (Thompson, McManus, & Voss, 2006). Animal Assisted Play Therapy™ (AAPT) is an intervention with an emerging evidence base (VanFleet & Faa-Thompson, 2017). The underlying mechanisms of AAPT could serve to enhance frustration tolerance, strengthen attachment bonds, and be a protective factor against further behavioral health distress (VanFleet & Faa-Thompson,
2017). AAPT is not a manualized treatment. Rooted in the tradition of play therapy, the model encourages exploration and healing through playful interactions. While playful involvement of a therapy animal can become a component of a wide range of therapeutic modalities, AAPT is guided by a series of considerations (VanFleet & Faa-Thompson, 2017). Some of the considerations are general best practices in psychotherapy; other considerations are specific to play therapy or AAPT. The considerations, and the associated tasks required of clinicians, are summarized in Figure 3. While AAPT can be implemented involving a number of non-human species including horses and cats, only dogs will be discussed in this section due to this being the species of interest in the current study.

Overall treatment goals include increasing client self-efficacy, enhanced attachment bonds, increased empathy and self-regulation, and development of problem resolution skills (VanFleet & Faa-Thompson, 2017). The age and presenting problem of the client, and the theoretical orientation of the therapist will impact the content of therapy for specific clients. Lessons learned in session model behavior changes to be made in daily life. For example, a child may participate in the process of training the therapy dog to complete new tasks and work with the therapist to process the animal’s reaction to the training process (VanFleet & Faa-Thompson, 2017). In turn, children learn how to maintain appropriate boundaries and appreciate the process of gaining mastery.
There is precedent for implementation of AAPT in an emergency housing program. Parish-Plass (2008), a clinician incorporating therapy animals into play therapy with children living in an Israeli emergency housing complex, documented a series of case studies \((N = 8)\) of shelter-based clients with whom she involved animals in psychotherapy. The demographic make-up of these clients is reminiscent of the American children living in shelters in Herbers et al.’s (2014) study. The children were living below the poverty line, and all the children had a history of either witnessing or being a victim of physical violence. Presenting problems at the beginning of therapy included aggression against other children, impulsivity, and physiological reactivity. Each of the eight cases described was considered to be a clinical success. To delineate common factors within the cases, Parish-Plass (2008) reviewed and coded written summaries of each case study. Several thematic similarities were identified, including the unconditional acceptance offered by the animal and the enhanced self-esteem arising from successful appropriate
interactions with the animal.

Reichert (1994) published a small study evaluating the impact of a play-based animal assisted therapy group designed to help children, ages nine through thirteen years old (N= 24), heal from the impact of sexual abuse. The group was implemented in three phases; first, the group provided psychoeducation about sexual abuse and the treatment group through playful activities; second, the group allowed participants to explore their traumatic experiences through the metaphors of play therapy activities; finally, the group instructed participants in methods of coping with difficult emotions and seeking future safety. A therapy dog was present for the group meetings, and the therapist integrated activities with the dog into the phases of treatment. After participating in the group, children measured significantly lower levels of depression and PTSD symptoms, as compared to pre-treatment. Without a comparison group, it is unclear whether the dogs added to the efficacy of treatment.

Fung (2015) wrote an in-depth case study of a seven-year-old boy with an Autism Spectrum Disorder with whom she implemented AAPT. Each session included a brief lesson about the dog’s body language and behavior, and then an open play session between the dog, child, and therapist. Sessions were recorded and coded for presence or absence of target behaviors by two graduate students. Target behaviors were identified from the client’s treatment plan, and included indicators of social skills. After fourteen sessions of AAPT, the client showed increased target behaviors since baseline measurements, including joint-attention with the therapist and waiting behaviors, including allowing the therapist to take turns in interacting with the therapy dog. In a one-month follow-up, the boy continued to demonstrate these behaviors at levels similar to those measures at post-treatment.

Both Fung’s (2015) and Reichert’s (1994) preliminary results speak to the potential
broader applicability of AAPT as a treatment for increasing socialization and decreasing symptoms of PTSD, and provide support for continuing research on the modality. Both clinical goals are aligned with intended outcomes of therapy for chronically homeless children, and are worthy of further exploration through the lens of AAPT. AAPT emerged out of the tradition of play therapy, and is supported by literature on the physiological impact of spending time with non-human animals, studies of symptom reduction in animal assisted interventions, and evidence of play behaviors among non-human animals. Each body of literature supports the therapeutic nature of AAPT.

**Importance of Play**

Play is an integral component of AAPT, and has long been recognized as an important part of child development. Anna Freud first recognized this importance in therapy; in the early twentieth century, she used play to build rapport with children in psychoanalysis and psychotherapy (Cushman, 1995). Donald Winnicott (1953; 1971), an Object Relations theorist, later wrote about play as the basis for change in therapy. Play therapy formally emerged as a field of study and practice in the mid-1940s. Axline (1974) introduced the notion of Rogerian or child-centered play therapy. This approach to treatment, also referred to as non-directive play therapy, is rooted in the assumption that children’s natural and spontaneous play process is oriented towards healing. The therapist is responsible for facilitating safety within the therapeutic context and bearing witness to the child’s process, but the child ultimately directs the play (VanFleet, Sywulak, & Sniscak, 2010).

Directive play therapy, an umbrella term for a wide range of solution-focused models, is an outgrowth of the more traditional child-centered models. Directive approaches stimulate the child’s playful instinct towards healing through interventions initiated by the therapist
(O’Connor, 2011). The degree to which the therapist directs the play is dependent on the clinical
goals of the intervention and the theoretical orientation of the therapist. An individual therapist
may use directive and non-directive approaches in different sessions or different parts of a
session, but the interventions are distinct. A directive approach might be favorable in situations
where the treatment is time-limited or where the client is impaired by extreme trauma or
cognitive challenges (Goodyear-Brown, 2010).

**Play Therapy Materials.** In play therapy, the clinician’s playroom is an important
component of the intervention. Under ideal circumstances, the playroom contains sufficient
space for clients to freely explore play materials and select toys that appeal to them in order to
express themselves. Typically, a play therapist would have puppets, art supplies, dramatic play
costumes, sensory toys, medical toys, and a dollhouse, among other toys. While specific toys
might vary, the overall goal is to encourage free expression through play (VanFleet, Sywulak, &
Sniscak, 2010). It is best practice to include toys that are reflective of the cultural and religious
experiences of the clients with which a play therapist works (Gil and Drewes, 2005). For
example, the primary investigator of the present study included several African American dolls
and figures, some wearing *hijabs*, Muslim head scarves, to reflect the majority culture of resident
families of the shelter.

**AAPT Materials.** A play therapist implementing AAPT would require additional
materials both to provide comfort for the involved animals, and to facilitate play between the
animals and clients. It is considered a best practice in AAPT to reserve a place in the playroom
for the therapy animal’s comfort. For a play therapy dog, this might include a water bowl, a
blanket or dog bed, some toys or bones; therapists might instruct clients to allow the therapy dog
a break when the dog retreats to this corner of the office (VanFleet & Faa-Thompson, 2017). To
facilitate playful engagement with a therapy dog, a therapist might stock the playroom with stuffed animals, rope toys, balls, toy traffic cones, or play tunnels. Clients might also engage with a therapy animal through care and nurture activities, so therapists might keep grooming brushes with the AAPT supplies.

Because clinicians implementing AAPT with dogs often integrate dog training into the therapeutic process, the playroom would include treats and training clickers. Clicker training is a technique within the framework of operant conditioning that employs positive reinforcement. The trainer pairs a “click” sound, often made using a small plastic device, with the primary reinforcer of a treat. To effectively train using a clicker, the trainer creates the click sound at the moment that the dog displays the behavior the trainer desired (Pryor, 2002). Before an animal is able to respond to clicker training, they must form an association between the primary reinforcer and the click sound; most dogs quickly make the association after hearing the click once or twice and being offered a treat. Clicker training is effective in training dogs to learn cues with multiple sequential parts, or in helping a trainer to achieve precise timing when reinforcing behavior (Chiandetti, Avella, Fongaro, & Cerri, 2016). In the AAPT context, clicker training is a useful tool in assisting young children or clients working towards greater impulse control to learn about cause and effect (VanFleet & Faa-Thompson, 2017). Children who participated in the present study had at least minimal exposure to the principles of clicker training, and several clickers and types of treats were available in the playroom.

**Play Therapy and Trauma.** All forms of play therapy recognize the developmental significance of play in childhood and the healing power of play for children who suffer. Through play, children have an opportunity to communicate their experiences in a developmentally appropriate medium that fosters emotional safety. Several conceptual and empirical articles have
addressed the potential role of play therapy in decreasing or preventing symptoms of post-traumatic stress following exposure to a potentially traumatic event. LeBlanc and Ritchie (2001) conducted a meta-analysis of 42 Randomized Controlled Trials on the effectiveness of play therapy. Overall, the meta-analysis found play therapy to be as effective or more effective than non-play therapy interventions as evidenced by increased post-treatment measures of emotional and social adjustment, decreased post-treatment measures of post-traumatic symptoms, decreased reports of problem behaviors, and increased reports of positive family member interactions. Using linear modeling, analysis of these results revealed a moderate effect size \( (d=0.66) \), which was maximized after approximately 30 sessions of play therapy. Across studies, effectiveness of the intervention was increased by involvement of parents or caregivers. This finding is relevant to the current study, as all children that received therapy at the research site also had sessions that involved their custodial parents.

A randomized controlled trial compared the efficacy of non-directive play therapy for treating post-traumatic stress to the efficacy of Trauma-Focused Cognitive Behavioral Therapy in a sample of refugee children who have been exposed to potentially traumatic event (Schottelkorb, Doumas, & Garcia, 2012). In Trauma-Focused Cognitive Behavioral Therapy, therapists teach coping skills to children to manage post-traumatic symptoms and then guide children in employing those skills as children create a written narrative of their traumatic experiences. The goal is to desensitize children to stimuli associated with the trauma through a gradual exposure process (Cohen, Mannarino, Deblinger, 2006). Trauma-Focused Cognitive Behavioral Therapy is an evidence-based practice that is supported by over 25 years of research, and is typically considered to be the “gold standard” in treating childhood traumatic stress. In fact, the research site for the present study exclusively implemented Trauma-Focused Cognitive
Behavioral Therapy prior to the hiring of the therapist trained and certified in AAPT (Wenocur, Parkinson-Sidorski, & Snyder, 2015).

In the randomized controlled trial, a sample of refugee children (N=31) was randomly assigned to receive either Trauma-Focused Cognitive Behavioral Therapy or non-directive play therapy for a period of at least twelve weeks (Schottelkorb, Doumas, & Garcia, 2012). Parent participation was required in both groups and post-traumatic stress symptoms were assessed prior to treatment, and after twelve weeks of treatment by both parent and child report. Across both groups, participants generally reported a significant decrease in frequency of post-traumatic symptoms after week twelve. The results suggest that non-directive play therapy and Trauma-Focused Cognitive Behavioral Therapy are similarly effective in reducing symptoms of post-traumatic stress in this population. There was a higher rate of treatment drop-out in the Trauma-Focused Cognitive Behavioral Therapy group than the play therapy group. The authors identified treatment engagement as a potential future area of study, citing that parents in the Trauma-Focused Cognitive Behavioral Therapy group tended to have less investment in treatment. For the present study, this finding is significant; the introduction of play therapy in the research site correlated with an increase in participation in the on-site therapy program.

Some preliminary research supports the efficacy of implementing play therapy in a homeless shelter with the goal of decreasing symptoms of post-traumatic stress and associated behavioral symptoms for children. Baggerly and Jenkins (2009) conducted a pilot study with a small sample (N=36) of children ages five to twelve years old who resided in a homeless shelter. Each child received between 11 and 25 sessions (45-minutes) of non-directive play therapy; standardized measurements of anxiety, depression, self-esteem, social and emotional development, and PTSD were administered prior to and at the completion of treatment. At post-
treatment, participants showed decreased symptoms of PTSD, anxiety, and depression, and increased capacity for responding to behavioral interventions designed to improve school performance. While these findings introduce a broad range of variables for future research, they bear relevance for the current study in demonstrating the potential positive impact of play therapy for children facing homelessness. Some of the specific measurable findings identified in Baggerly and Jenkins’ (2009) study, including decreased PTSD symptoms and increased responsiveness to school-based interventions, represent the targeted therapeutic goals for children who participated in the current study.

**Play Across Species.** Play behavior is not unique to humans. In fact, neurological evidence indicates that play behavior is an expression of one of vertebrates’ most primal emotional experiences. Panksepp (1992) coined the term “affective neuroscience,” the study of neural mechanisms of emotion. The field of affective neuroscience has delineated seven basic emotions: care, lust, seeking, rage, fear, panic/grief, and play. Each basic emotion corresponds to a unique anatomical, neurochemical, and functional organizational pattern that is homologous among all mammalian species. Simply put, neural imaging has shown that the homologous subcortical structures of the brain of a rat, a dog, or a human are in use during play (Panksepp, 2010). Young animals have strong urges to engage in play behavior and, through play, learn the social norms of their species. Interspecies play arises from these urges and can be mutually beneficial for both species in meeting these developmental goals, assuming that the individual animals have an understanding of the other species’ body language (Cordoni, Nicotra, & Palagi, 2016). This would be particularly true for humans and canines, who have co-evolved over centuries.

The historical relationship between humans and canines bolsters the healing potential of
this play. Dogs are uniquely positioned to elicit playful interactions in children. When dogs’ basic survival needs are met, there is a natural tendency towards play both with other dogs and with companion humans. Decades of observation of canine play has revealed that dogs signal honest displays of trust and fun, and that dogs will regulate one another’s play. For example, dogs exhibit a “play bow,” in which their front paws are outstretched and low and their hind legs are pointed upwards, to signal that they are ready to play (Bekoff, 2015). Further study of canine-human play suggests that dogs can engage in interspecies play that adheres to the same guidelines as canine play (Cordoni, Nicotra, & Palagi, 2016). Therapists implementing AAPT with dogs educate clients about these signals and facilitate a parallel process of honest communication and rule following (VanFleet, 2008). For example, a therapist might teach a client about the concept of a play bow and subsequently facilitate a conversation about the importance of responding to non-verbal body language.

**Physiological Impact of the Canine-Human Bond.** Companion dogs have long been considered to have a calming presence. Hunt and Chizkov (2015) performed a controlled lab-based study of college undergraduates (N=107) in which participants were administered a series of psychometric measures after completing a written prompt. Participants were randomly assigned into two groups; one group was instructed to write about a traumatic memory, while the control group was instructed to write about an innocuous subject. Participants were further divided into groups – half of participants had a dog present during their writing exercise, while the other half did not. Based on scores on the Springer State Anxiety Inventory, anxious arousal was determined to be higher in the group that wrote about traumatic experiences. When only considering individuals who wrote about traumatic memories, participants in the dog condition were found to have lower anxious arousal than those in the non-dog condition. The results
suggest that while trauma memories increase physiological arousal, the presence of a dog can mediate the physiological response in order to allow for writing or speaking about trauma. This has implications for animals involved in therapy work and suggests that physiological symptoms that might inhibit progress in therapy might be decreased when a therapy dog is present.

Study of canine-assisted therapy suggests that there are therapeutic implications of the modality that are physiological in nature. Tsai, Friedmann, and Thomas (2010) conducted a quasi-experimental study of a small sample (N=15) of children ages 7 to 17 who were hospitalized. To measure the efficacy of animal assisted therapy as an intervention to relieve stress and anxiety associated with inpatient medical care, children were assigned to receive visits from a therapy dog or a child life specialist who engage the child in developmentally appropriate play. The study was quasi-experimental as children were screened for appropriateness for the therapy dog visit and assigned to the child life specialist condition if they had an allergy to or fear of dogs. Each child’s blood pressure and heart-rate were measured eighteen times over the course of the intervention; brief questionnaires about the child’s state anxiety and medical fears were administered prior to and following the intervention. Across both groups, children reported lower anxiety and decreased medical fears following the intervention. In the therapy dog condition, children’s heart rate and blood pressure decreased at a greater rate than in the child life specialist condition. Decreased measures of heart rate and blood pressure persisted for several minutes after the intervention. The results of this study speak to the potential physiological impact of AAPT for children exposed to trauma, as post-traumatic stress is associated with high blood pressure and heart rates.

**Symptom Reduction.** There is precedent for incorporating therapy dogs into the treatment of complex PTSD. Yount, Ritchie, St. Laurent, Chumley and Olmert (2013) conducted
a series of interviews with veterans who had been involved in training service dogs. The program was designed to help veterans find gainful employment that also offers a sense of purpose; veterans learned the marketable skill of training dogs and assisted in training service dogs that would eventually serve other military veterans. The program was impactful beyond the provision of job skills as evidenced by self-reported decreased PTSD symptoms, increased impulse control and improved family dynamics. Although the article does not represent the results of a formal study, and self-report measures have limited reliability, the authors note that this informal study might provide the groundwork for future research. The authors draw connections between the structure of dog training and the need for predictability in the treatment of PTSD. Because AAPT can include tricks training, the suggestions of Yount et al.’s (2013) article can apply to this model (VanFleet and Faa-Thompson, 2015). Training a dog to learn a new trick may facilitate feelings of safety and predictability in a child client.

Among children exposed to potentially traumatic events, animal assisted therapy has also been shown to reduce symptoms of PTSD. A study of children ages 7 to 17 years (N= 153) healing from sexual abuse evaluated the efficacy of groups designed to treat post-traumatic stress symptoms. Participants were split in to three groups, two of which incorporated AAT into the manualized group treatment. Each child participated in twelve sessions of group therapy and was administered standardized measures of PTSD symptoms, depression, and anxiety (Dietz, Davis, & Pennings, 2012). At the end of the study, participants of all groups demonstrated decreased symptoms of post-traumatic stress, and participants in the conditions that included therapy dogs showed decreased symptoms specifically in the areas of attachment related symptoms and dissociation. These results suggest that therapy dogs have the potential to decrease symptoms of post-traumatic stress commonly reported among homeless children, and provide further support
for implementation of canine-assisted therapy among this population.

**Projective Drawing Research**

Because the study sought to understand and share perspectives of children living in emergency housing, qualitative methods were used. This ensured that participants had the opportunity to provide feedback on the intervention in their own voice and in a developmentally appropriate manner. Malchiodi (1998) explains that children’s drawings communicate how they see the world. For example, if a child includes a neighbor in her family picture, it may signify that that neighbor plays an important role in that child’s life. Projective drawings – drawings elicited by open-ended prompts and analyzed contextually - emerged as tools for measuring a wide range of phenomena in clinical and research settings in the 1920s (Malchiodi, 1998). Since then, numerous projective drawings tasks have been developed (Scott, 1981). Burns and Kaufman (1987) developed a commonly-used task, the Kinetic Family Drawing; in this measure, children are asked to draw a picture of their family doing an activity. The drawing would then be analyzed based on its perceived thematic context in order to understand a child’s perception of family dynamics.

In its traditional form, drawings generated using the Kinetic Family Drawing procedure can be coded using a Jungian-based system. While acknowledging the inherent benefit of analyzing children’s experiences in this fashion, Malchiodi (1998) was critical of the traditional coding scheme and its dogmatic adherence to Jungian symbolism. Singh and Rossouw (2015) used the Kinetic Family Drawing procedure to explore the attachment experiences of Australian schoolchildren from lower socioeconomic backgrounds but did not use the traditional Jungian coding scheme. Rather, the authors used a constructivist grounded theory approach to coding, similar to open coding methods used for qualitative interviews. With the goal of better
understanding the emotional experience of attachment disruptions, the authors administered the Kinetic Family Drawing to a sample of children (N=43) aged 5 to 12 years old and compared the content of children’s Kinetic Family Drawing drawings to the results of a series of assessment, including a measure of attachment style. The study revealed some positive correlation between elements of Kinetic Family Drawing drawings and attachment security. For example, children who drew figures close together in the drawing were more likely to have a secure attachment relationship.

Projective Drawings: Trauma and Homelessness. There is precedent for use of projective drawings to explore the experiences of children and families living in shelters following exposure to trauma. Backos and Samuelson (2017) administered several projective drawing assessments, including the Kinetic Family Drawing to a sample of mother (N= 43) and child (N = 56) dyads who experienced domestic violence; families were recruited through local domestic violence service providers including shelters. The Kinetic Family Drawing drawings were analyzed using Burn’s (1982) traditional Kinetic Family Drawing coding system and using a qualitative approach based in constructivist grounded theory. The research team also conducted a semi-structured interview, the Clinician-Administered PTSD Scale, to determine whether participants met diagnostic criteria for PTSD. Participants were sub-divided into mothers (N=20) and children (N=37) who met criteria for PTSD, and mothers (N=23) and children (N=19) who did not meet criteria for PTSD.

Backos and Samuelson’s (2017) study did not find any significant thematic differences in Kinetic Family Drawing between sub-groups using Burn’s (1982) coding scheme was applied, but several thematic differences emerged when drawings were analyzed using constructivist grounded theory. Mothers and children meeting PTSD criteria tended to draw figures that were
physically separate from one another, and depict figures with negative or neutral facial expressions; mothers and children not meeting PTSD criteria drew figures with positive facial expressions and in close physical proximity. Children meeting criteria for PTSD often depicted negative interactions between figures, and scenes of isolation and estrangement. These findings inform interpretation of the drawings created in the current study; not only do they provide some potential visual indictors of trauma symptoms, but also the overall robustness of the themes elicited from the grounded constructivist approach to coding, as compared to the traditional Kinetic Family Drawing coding scheme, supports the use of open coding in the current study.

**Projective Drawings and Attachment**. Kaiser’s (1996) Bird’s Nest Drawing was designed to assess attachment security through analysis of a drawing of a birds’ nest. The bird’s nest figure was chosen because of its symbolic significance in comparison to early infant-parent attachment experiences. The figure also allows for some emotional distance from family dynamic without the emotional implications of drawing their own family (Kaiser, 2009). This is particularly important for children with early separations from their families, such as children in foster care (Kaiser & Deaver, 2009). Some iterations of the Bird’s Nest Drawing have also asked children to write down or tell a brief story about their picture or provide a title for their picture, and coded the content of these stories for qualitative analysis (Kaiser & Deaver, 2009).

In the Bird’s Nest Drawing, children are asked to draw a picture of a birds’ nest, and asked a series of open-ended questions about the drawing. Harmon-Walker and Kaiser (2015) conducted a validity study of the Bird’s Nest Drawing with undergraduate college students (N=136) comparing visual elements of Bird’s Nest Drawing drawings with the results of two quantitative measures of attachment security that have been empirically studied for validity and reliability. The Experiences in Close Relationships Questionnaire (ECR) measures adult
attachment style, and is the most widely used measure of adult attachment style. Participants complete a series of true-false statements regarding their relationship with their parents, partner, and peers; respondents’ attachment styles are categorized as secure, avoidant, preoccupied, or fearful on responses for each individual relationship and overall. For the purposes of the study, only the overall attachment style was considered for analysis. The Inventory of Parent to Peer Attachment measures style of adolescent attachment to parents. The measure asks respondents to rate their level of agreement (ranging for “Strongly Agree” to “Strongly Disagree”) for a series of statements about their relationship and attitudes towards their parents and their peer group. For each relationship scale, numerical scores for levels of trust, and alienation are determined by responses to statements categorized in those three categories.

Harmon-Walker and Kaiser (2009) compared respondents’ Bird’s Nest Drawing drawings to the results of the Experiences in Close Relationships Questionnaire and Inventory of Parent to Peer Attachment. For each Bird’s Nest Drawing, two independent raters completed an Overall Impressions Rating sheet that provides some general description of attachment style, and asks raters to choose which attachment style is represented by the Bird’s Nest Drawing graphic using a checklist of characteristics. Using the Overall Impressions Rating, the Bird’s Nest Drawing had moderate to high interrater reliability on several items, including the presence of birds as an indicator of secure attachment ($\kappa = .924$), and the overall impression among the four categories of attachment style ($r = .736$). Chi Square analyses were conducted to assess frequency of particular graphic elements across groups of high and low Experiences in Close Relationships Questionnaire and Inventory of Parent to Peer Attachment scores. An association was found between Overall Impressions Rating and score on the attachment to parent subscale of the IPPA ($\chi^2 = 12.7333, p = .006$), and the inclusion of a family of birds correlated with high overall
Inventory of Parent to Peer Attachment scores. The study, while focused on young adults, provides some preliminary support for projective drawings as a way to assess attachment style.

Summary

Overall, the literature on child and family homelessness suggests that the need for appropriate, trauma-informed behavioral health services is great, yet availability of these services tends to be limited. The literature also suggests that when appropriate services are available, families might not access them due to prior negative experiences with service providers, geographical transience, and focus on physical survival needs. Animal assisted therapy, specially AAPT with canines, serves as a compelling modality to introduce to this population. Literature on AAPT suggests that the model is not only well-suited to address both trauma histories and attachment needs, but also able to engage individuals that might not otherwise seek treatment. Finally, the literature on projective drawing studies suggests that drawings are a developmentally-sensitive way to understand children’s worldviews. Due to the vulnerable nature of the population of interest, projective drawings provide a compelling frame through which to explore homeless children’s experiences participating in therapy.

Research Design and Methods

The population of interest is children who live in an emergency housing facility for homeless women and their children. This particular facility is located in a major Mid-Atlantic metropolitan area, and houses 29 women and up to 70 children on any given night. The average length of stay is approximately nine months, and residents have supportive case management and ancillary onsite services including wellness and nutrition programs. The facility has an onsite, licensed clinician who works with a qualified therapy dog. The dog has passed the American Kennel Club’s (AKC) Canine Good Citizen test and is an approved play therapy dog by the
International Institute for Animal Assisted Play Therapy™ (IIAAPT); the therapist is a Certified Animal Assisted Play Therapist™. Participation in onsite therapy is voluntary, and residents are not required to involve the therapy dog in their treatment. Likewise, children not enrolled in therapy can choose to have recreational visits with the dog, under the supervision of an adult.

**Eligibility Criteria**

Children who have had contact with the dog, in either a clinical or a recreational context, were eligible to participate in the study. To be included in the recruitment procedure, children must have had at least three instances of contact with the dog. For the purpose of the study, an instance of contact refers to a formal therapy session or an informal one-on-one supervised visit with the dog. The onsite therapist will have been present for the instance of contact. For inclusion, the child’s last instance of contact with the dog must have occurred no more than twelve months prior to recruitment. Initially, children under the age of seven at the time of recruitment were to be excluded from the study, due to this being the legal age of assent. The sampling frame was ultimately expanded to include children as young as five, with the stipulation that children must be at least in Kindergarten at the time of data collection. Inclusion of younger children in the sampling frame is consistent with the research protocols for several studies that collected data from comparable populations using projective drawings (Singh and Rossouw, 2015; Backos & Samuelson, 2017).

**Administrative Arrangements**

Collection of data was facilitated by the relationship the research team formed with the shelter site. A letter of support (Appendix C) details the nature of this relationship. Because the primary investigator was also an employee of the research site, an MSW student research assistant was hired to direct outreach and recruitment efforts. The research assistant was
responsible for reviewing case files with the primary investigator and attempting to contact families eligible for research participation by letter or telephone call. To further support participant autonomy, the research assistant was responsible for gaining informed consent from participants’ parents or guardians and assent from the child participants. During the data collection phase, the research assistant assumed responsibility for conducting the parent interview, which included questions designed to elicit feedback about treatment received while in the shelter. The rationale was that parents might be more truthful about negative experiences in therapy if a former shelter employee was not conducting the interview.

**Sample and Recruitment**

The primary investigator and a research assistant identified children meeting inclusion criteria through a chart review process. Twenty-one children, representing fourteen families, met criteria for inclusion in the study. Eleven children, representing six families, participated. If a child met criteria to participate, the research team mailed a recruitment letter to the last known address of the child’s custodial parent; one week later, the research team made follow-up phone calls to families to gauge interest in participating in the study. None of the fourteen custodial parents replied to the recruitment letter alone; all of the six families, with eleven children, who participated were recruited by telephone. Five families, with six children, did not have phone numbers in service. Two families, with two children, did not reply to recruitment letters or telephone message. One family, with two children, initially agreed to participate in the study but ultimately opted out of the study. Because the study is qualitative in nature, recruitment terminated once theoretical saturation, the point when “collection of data does not shed any new light” on the research topic, was reached (Mason, 2010).
FETCH (Figure Evaluation of Therapy Canine and Human)

In this projective drawing task, participating children were asked to draw a picture of a child and a dog. After obtaining informed consent (Appendix A) from the parent or legal guardian of each participant, and assent (Appendix B) from each participant over the age of seven, the investigator met with the child one-on-one to administer the FETCH. The research assistant met with the parent or guardian concurrently and in a nearby room. Although the consent and assent forms were completed in the same room, the parent was not present for the child’s drawing, and was not permitted to view the drawing once completed. The FETCH was administered in a common room familiar to the family (e.g. the childcare room or the teen lounge area). No interviews occurred in the therapy room, and the therapy dog was not present during the interviews.

Each child was provided with an 8.5 x 14” piece of white paper, a box of eight primary colored crayons and one No. 2 pencil. After the investigator prompted the child to, “draw a picture of a child and a dog,” the child had approximately ten minutes to complete the drawing. Although extra paper was available, children were encouraged to complete the drawing on one sheet of paper due to the potential information provided by erasure (Harmon-Walker & Kaiser, 2009).

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<th>Sample Interview Questions and Prompts</th>
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<tr>
<td><strong>Questions for Child</strong></td>
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<tr>
<td>• Tell me about the dog over there.</td>
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<tr>
<td>• Do you know the dog?</td>
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<tr>
<td>• What is it like to spend time with the dog</td>
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<td>• What is the dog doing?</td>
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<td>• Is/Was the dog doing that with you or without you?</td>
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*Table 5. Sample interview questions for FETCH administration*
As per the projective drawing literature on child’s art therapy work, once the child completed the drawing, the investigator asked the child to tell or write a story about the drawing, depending on the child’s age and preference. The investigator also asked whether the child has a title for their drawing. If the child was unwilling to tell a story, or needed assistance in starting the story, the investigator posed some preliminary interview questions. Although these questions were tailored to the individual participant, the basic structure of the interview is summarized in the sample questions above (Table 5).

**Parent Interview**

A research assistant met with the custodial parent or caregiver for the duration of the child’s FETCH interview. This meeting allowed the parent or caregiver to ask any further questions about the research project and to provide additional information about the child’s trauma history and subsequent treatment history. Because the Therapeutic Services Intake Form (Appendix D) is administered at the beginning of therapy, the parent or caregiver may not have felt comfortable disclosing sensitive information about the child. The parent interview was an opportunity for the custodial parent to share information in greater detail. The research assistant reviewed each child’s competed Therapeutic Services Intake Form with the custodial parent, and documented any new data provided by the custodial parent. The research assistant also conducted a brief interview with the parent, based on the following questions (Table 6). The Therapeutic Services Intake Form, along with any new data, and a written transcript of the parent interview also became part of the research data for that participating child.
Sample Parent Interview Questions

- How has your child or children been doing overall since leaving the shelter?
  - In school?
  - Socially? Behaviorally?
- Has your child or children had therapy since leaving the shelter?
  - If so, how has this compared to AAPT received in the shelter?
  - If not, do you plan to seek therapy in the future?
- Does your child or children mention the therapy dog?
  - If so, in what context? Does he or she discuss specific memories about the dog?
- Has your child or children spent time with dogs since leaving the shelter?
  - If so, in what context? Does he or she seek contact with dogs? How would you describe his or her interactions with dogs?
  - If not, does your child or children avoid spending time with dogs?

Table 6. Parent interview questions

Retrospective Chart Review

Per the administrative arrangement with the research site (Appendix C), copies of the initial intake form and standardized measures completed during treatment also became part of the research data. Client and family names were redacted from these records and records were assigned an alphanumeric code to connect this information with other data in the study. If additional information was added to the intake form during the parent interview, this was documented in the parent interview transcript. Because the study was qualitative in nature, the sample size was insufficient to conduct quantitative analyses on the standardized measures. Instead, information from the clinical chart was used to provide some context to the analysis of the projective drawing and the interview transcript.

Therapeutic Services Intake Form

At the beginning of therapy, the child’s parent or caregiver completed a clinical intake questionnaire (Appendix D). The questionnaire includes questions about the child’s presenting psychosocial problems, and about the child’s early life history and developmental milestones. To
provide additional context, the questionnaire includes questions about the child’s educational, medical, and trauma history. There are also several questions about the client’s strengths and best qualities, the parent-child relationship, and the client’s interests.

**Trauma Symptom Assessments**

All therapy clients were administered a symptom inventory for PTSD at the beginning and the end of treatment; depending on the length of treatment, the clinician may have administered a mid-treatment measure. The specific measure was chosen based on the child’s age and developmental level. Older children and adolescents were assessed using the UCLA PTSD Index – Adolescent Version or the UCLA PTSD Index – Child Version (Rodriguez, Steinberg, & Pynoos, 1999). A pictorial assessment, the Cameron Complex Trauma Inventory (CCTI), was used to assess younger children or clients who, due to reading level or personal preference, would be assessed more effectively with the pictorial format.

**UCLA PTSD Index.** This instrument was designed to assess symptoms of PTSD in children and young adults ages 7-18. While the original version was based on the DSM-III criteria for PTSD, the instrument has been revised to adhere to subsequent editions of the DSM. Because the participants received therapy during a time of transition from the DSM-IV-TR to the DSM-V, the versions administered reflect the diagnostic criteria of the DSM-IV-TR (American Psychiatric Association, 2000). Both the child and adolescent versions of the UCLA PTSD Index begin with a list of potentially traumatic events; participants are asked to identify any potentially traumatic events they have witnessed or experienced. The instrument then includes a series of symptom frequency questions – 20 for the child version and 22 for the adolescent version. Each question signifies a symptom of PTSD and frequency is reported using a Likert scale that ranges from 0 (“Never”) to 4 (“Most of the Time”). Likert ratings from each symptom are totaled to
generate a symptom severity score ranging from 0 to 88 on the adolescent version and 0 to 80 on the child version. On both versions of the measure, any scores higher than 38 are considered clinically significant (Rodriguez, Steinberg, & Pynoos, 1999). The instrument has been shown to have high internal consistency and reliability across age ranges (Steinberg et al., 2013).

**Cameron Complex Trauma Interview (CCTI).** This instrument is both a pictorial assessment tool and a structured clinical interview designed for children ages 5-11. The pencil-and-paper CCTI features a cartoon dog named Cameron, who is depicted experiencing a series of potentially traumatic events. In administering the CCTI, the clinician shares these images with the child and asks the child to identify which, if any, of these experiences have occurred in the child’s life or memory. The structured interview guide provides prompts for follow-up questions regarding each identified potentially traumatic event. Symptom frequency is measured on Likert scales for 21 PTSD symptoms of early childhood. The CCTI includes a picture of each symptom, and the Cameron character’s face is the basis for the Likert scale. As is the UCLA PTSD Index, frequency is rated from 0 (Never) to 4 (Most of the Time), though each item includes four of Cameron’s facial expressions ranging from neutral to distressed. While the CCTI is a new psychometric tool, the preliminary research suggests internal consistency and convergent validity with similar measures of PTSD symptoms (King, Solomon, & Ford, 2016).

**Protection of Human Participants**

Protection of participants’ wellbeing was of the highest priority to the researchers. The appropriate parent or guardian received a thorough description of the purpose, benefits, and risks of study participation in the informed consent form. In meeting with the parent or guardian providing consent, the investigator explained that the parent could not be present for the child’s interview and that the drawings would become property of the research study. Because drawing
may elicit strong emotions from the child, the parent’s presence may change the nature of the child’s drawing. If a parent or guardian did not feel comfortable with these terms, they were not required to consent to the study. Moreover, the researcher explained the study to children in a developmentally appropriate manner and gained assent from all child participants over the age of seven. The following emergency procedure was developed for the protection of participants: *in the event of an emergency, such as a participant becoming agitated, the investigator will immediately stop the interview and offer one of several behavioral health resources, including the mobile crisis response unit.* The procedure was discussed with shelter staff, who helped determine the most relevant to provide for participants, prior to the data collection phase. The research assistant explained the procedure to parents while obtaining informed consent.

All data obtained from interviews continue to remain confidential and documents related to the study were kept under lock-and-key during the data analysis phase. Only members of the research team have had access to the records, and all individual data were destroyed once data analysis was complete. No identifying information was retained, and all participant data were labeled with a unique alphanumeric code. To preserve data about familial relationships between participants, alphanumeric codes were distinguished by a letter for each family, and a subsequent number for each individual family member. All names, birthdates, and other identifiers were redacted from clinical charts; any identifiers written on the FETCH drawing were also redacted. Minimal demographic information, such as child’s age and race/ethnicity, remained part of the clinical records.

Participants were monetarily compensated for their time. Families received fifteen dollars in cash for each child’s participation which translated to roughly fifteen dollars per hour of participation. In order to defray the cost of transportation to the research site, each participating
family member also received two public transportation tokens. As a token of gratitude for participation, each child was given a small pad of paper and the small box of crayons used for the projective drawing task.

**Analysis**

For each of the eleven participating children, there were several materials that became part of the study data; a completed FETCH drawing, a written transcript of the child’s interaction with the investigator, a clinical chart including notes and assessment measures, and a written transcript of the custodial parent’s interview with the research assistant. All but three of the participants had siblings that also took part in the study. Inclusion of family data can add contextual depth to analysis of individual participant data. Therefore, a family case history was constructed for each sibling group based on information provided in each child’s clinical chart and in the parent interview.

To explore fully and express the dynamic relationships among family members, the primary investigator developed a genogram, a pictorial display of familial relationships, for every family group (McGoldrick, Gerson, & Petry, 2008). The genograms, which depict each child’s nuclear family and first-degree relatives, also include information about the family’s trauma history and the composition of family members that resided in the shelter. The genograms were developed using information from the child’s clinical chart, and from the parent research interview. The genogram and family case study provided some context for analysis of the child’s FETCH drawing and accompanying narrative. Where appropriate, elements if the child’s clinical record were incorporated into the analysis.

**Analysis of FETCH Drawing**

Each child’s FETCH drawing was analyzed individually for both developmental and
emotional content. Using literature on projective drawings, art therapy, and art development, the primary investigator sought to explore the ways that each child communicated their experiences and worldview through their FETCH drawings. Because each family history indicated exposure to potentially traumatic events, literature on traumatic exposure and projective drawings was also consulted to identify any potential correlates of trauma in the elements of children’s drawings (Backos and Samuelson, 2017). Visual elements of interest may include, but are not limited to the dimensions and relative size of each figure, the figures’ placement on the page, the presence or absence of scenery or visual context.

**Developmental Content.** Each drawing was analyzed through the lens of Lowenfeld and Brittain’s (1982) widely-used Stages of Artistic Development (Figure 6). The stages encompass typical developmental milestones depicted in children’s drawings, and outline a rough age at which a child might exhibit drawings consistent with a particular stage. Overall, the stages chart a developmental course of drawings that are progressively more representative of actual figures and increasingly complex.

<table>
<thead>
<tr>
<th>Stage Name</th>
<th>Expected Age of Child</th>
<th>Typical Elements of Drawings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scribbling Stage</strong></td>
<td>1-3 Years</td>
<td>• No connection between figures drawn and Children might name the scribbles towards the end of this stage</td>
</tr>
<tr>
<td><strong>Pre-Schematic Stage</strong></td>
<td>3-4 Years</td>
<td>• First attempt at communication through drawings Typically uses circles and lines</td>
</tr>
<tr>
<td><strong>Schematic Stage</strong></td>
<td>5-6 Years</td>
<td>• Figures represent actual objects, and children develop schema for commonly-drawn objects • Correlation between relative size of figures and importance to the child • Inclusion of a grounding line</td>
</tr>
<tr>
<td><strong>Dawning Realism Stage</strong></td>
<td>7-9 Years</td>
<td>• Increased sophistication of spacial relationships Increased complexity of schema</td>
</tr>
<tr>
<td><strong>Pseudo-Naturalistic Stage</strong></td>
<td>10-13 Years</td>
<td>• Begin to use light and shadowing in drawing • Increased realism in • Frustration is common; children benefit from encouragement</td>
</tr>
</tbody>
</table>

*Table 7. Lowenfeld and Brittain’s (1982) Stages of Artistic Development*
Malchiodi (1998) wrote of the importance of considering contextual factors to explain discrepancies between a child’s chronological age and their current stage of artistic development. A child may consistently draw at a lower developmental level due to chronic exposure to trauma, disruption in educational experiences, or learning disability (Backos and Samuelson 2017; Benviste, 2005; Singh and Rossouw, 2015). Furthermore, a child who typically draws at the appropriate developmental level may draw at a lower level during times of uncertainty (Malchiodi, 1998). For example, a child prompted to complete a projective drawing might draw at a rudimentary level due to the novelty of the situation or disengagement from the task. For each child, the primary investigator compared the schematic elements of the FETCH drawing to the expected developmental content of the drawings. If the child’s drawing appeared to be below the child’s developmental level, the investigator reviewed the child’s clinical chart to identify potential explanations for the discrepancy. Explanations might include frequent changes in educational placement, or a history of occupational therapy services for development of fine motor skills.

**Emotional Content.** FETCH drawings were also analyzed for indication of emotional elements. Using Malchiodi’s (1998) manual of art therapy, Burns and Kaufman’s (1987) K-F-D manual, and literature on Kaiser’s (2009) Birds’ Nest Drawing as a guide, the primary investigator identified any signs of emotional content in the drawings’ overall composition, choice of color, and placement of figures. Rather than rigidly adhering to coding manuals that identify a particular element as representing a particular emotional experience, the investigator considered emotional indicators within the context of the drawing as a whole. For example, while the Burns and Kaufman (1987) coding scheme might identify a figure drawn in darker colors as having negative emotional connotations, the child might share that the colors used are
associated with a happy memory. Children’s accompanying narratives were also analyzed individually and in conjunction with the FETCH drawing. The narratives include the stories that children told after completing their drawing, and any verbal communication that the child made with the investigator during the drawing. Whether the client’s description of the drawing is congruent with the themes and emotional content expressed in the drawing is of great significance to the analysis. For example, it is notable if a child depicts a figure as having a smile but describes the figure as sad.

**Thematic Analysis**

Using a grounded constructivist approach to analysis, the primary investigator identified broader themes that emerged in the drawings and narratives across participants. The investigator first read narratives and reviewed drawings to develop *in vivo* codes, which emerged from the data at face value. *A priori* codes were added after a focused reading of the narratives and observations of the drawings for concepts that were relevant to the research question, such as attachment, psychological development, and meaning making (Padgett, 2008). Because the investigator had access to clinical charts for each participant, as well as interviews which each custodial caregiver, data from these sources was integrated into the development of *a priori* codes. If a child’s play themes during therapy included content similar to or evocative of those included in the FETCH drawing and narrative, these were included in the analysis. Similarly, custodial parents often provided additional information about the child’s relationship with the therapy dog during their interview.

**Limitations**

The study and its methodology gave rise to a robust data set that allowed for rich analysis. However, there were several limitations in both the design of the study and in the actual
data collection process that impacted the results and analysis of the study. The study design was rooted in the literature on the needs and experiences of chronically homeless families (Guarino & Bassuk, 2010; Herbers, Cutuli, Monn, Naryan, & Masten, 2014). Because the sampling frame was comprised of the residents of one homeless shelter, the results only speak to the experiences of homelessness in this specific context. The shelter site had several features that distinguished it from other shelters across the country, and even in the same city. For example, the shelter’s physical layout allows for the resident families to each have a room; other shelters house multiple families in the same room. The shelter site staff participate in ongoing training in trauma informed care and make a concerted effort to put trauma informed principles into practice. Finally, the in-house mental health services are a unique facet of this particular shelter; none of the other shelters in this particular city have in-house therapy services. The factors that distinguish this shelter from its peer organizations might impact the way that residents of this shelter respond to AAPT. To further explore the impact of AAPT on chronically homeless families, similar studies could be conducted with clients from a broader range of homeless services provider.

Although data collection continued until theoretical saturation was met, the number of eligible families without working phone numbers limited the scope of the study’s findings. Because of the transient nature of the population, it is common for research on chronically homeless families to face similar challenges in recruitment (Brumley, Fantuzzo, Perlman, & Zager, 2015). Families that maintain a consistent phone number might be qualitatively different from families who do not retain those numbers. Therefore, the themes that emerged from the current study might not fully reflect the experiences of homeless families. Specific to this data collection process, the children who participated in the study ranged from six to eleven years old.
This represents a subset of the children who received AAPT while in the shelter, who ranged in age from three to eighteen years old. While the current study provides a focused set of results about the experiences of school-aged children of homeless families, but does not represent the full age-range of the population of interest.

**Findings**

Eleven children, ranging in age from six to eleven years, participated in the study. These eleven children represent six families, and all six mothers also agreed to be interviewed about their children’s experiences in AAPT. All participating families self-identified as African American. Seven participating children identified as female; four identified as male. At least one member of each family was enrolled in onsite therapy and worked with the therapist trained in AAPT. Siblings who did not explicitly receive AAPT met criteria for the study in one of two ways. Some were enrolled in therapy with another clinician and made recreational visits to the therapy dog. Others participated in family AAPT sessions as part of their sibling’s treatment. For each of the six families, therapeutic and recreational interactions with the dog occurred on at
least a bi-weekly basis. All therapy sessions were forty-five minutes long; recreational visits with the dog were approximately fifteen minutes long.

Along with a copy of each participant’s FETCH drawing and a summary of their FETCH story, a case vignette for each family was included below. The vignettes began with a family genogram and a brief family history of factors relevant to the children’s psychotherapy treatment and the family’s entrance into the shelter system. Each genogram followed the conventions of the symbol key (Figure 1), and visually represented the children who participated in the study, and the family members who resided in the shelter. The genograms also denoted family members that left the shelter before the entire family’s departure. Traumatic events, particularly those that contributed to the family’s homelessness, are indicated on the genogram. When a singular factor precipitating the family’s homelessness could be identified, this was denoted on the genogram. In some cases, multiple precipitating factors were indicated.

Case studies also included a summary of children’s work with the sandtray and accompanying figurines, major components of contemporary playrooms. A sandtray is typically a wooden or plastic container that fits on a tabletop and has surface area sufficiently large enough for clients to place multiple miniatures inside. A full collection of miniatures would include items representing people and families; a wide range of land and sea animals; plants and trees; rocks, stones and shells; household objects; fantasy and fairy tale items; symbols from world religions; and buildings and vehicles (Homeyer and Sweeney, 2017). Clinicians utilize sandtray for directive and non-directive interventions. Depending on the theoretical orientation of the play therapist, they might instruct a client to create a picture or scene, or prompt clients to use sandtray miniatures to tell a story (Taylor, 2015). The primary investigator in the present study frequently incorporates sandtray work into AAPT, sometimes instructing clients to tell stories
using miniatures to the therapy dogs.

Two findings underscored the case studies for each participant: the evidence of traumatic experiences found in the children’s drawings and narratives, and mothers’ positive descriptions of their child’s interactions with the therapy dog. Specific instances of trauma content and parent descriptions of the therapy dog were included in individual case vignettes. However, an overall summary of each finding was included to situate each case vignette in the larger context of the results of the study.

**Post-Traumatic Content.** Ten of the eleven children drew in a manner corresponding to an earlier developmental level in Lowenfeld and Brittain’s (1982) stages of artistic development. The children’s rudimentary drawings could be explained by frequent disruptions in schooling, limited availability of art supplies during leisure time, or discomfort with the unfamiliar setting of the research task. While each of these factors likely contributed to the rudimentary nature of children’s drawings, most contemporary scholarship has identified trauma as a correlate of delayed artistic development (Benviste, 2005; Singh & Roussouw, 2015, Backos & Samuelson, 2017). The most common indicator of delayed artistic development was the lack of geographic context or scenery, including the lack of a grounding line. These elements typically emerge in the *schematic stage*, when children are between five and six years old (Lowenfeld & Brittain, 1982). Even without the overall deficit in artistic development, these serve as indicators of post-traumatic symptoms; children in traumatized populations typically draw figures in isolation from their surroundings (Malchiodi, 1998; Backos & Samuelson, 2017).

Research on projective drawings in traumatized populations provided additional insight on indicators of post-traumatic symptoms. Backson and Samuelson (2017) found that children meeting criteria for PTSD tended to draw figures far away from each other; similarly, Singh and
Roussouw (2015) identified a correlation between the strength of children’s standardized measures of attachment bonds and the proximity of figures drawn. In the current study, none of the child and dog figures were drawn in physical contact with one another. While many drawings depicted figures in close proximity, some of the child and dog figures were separated by objects including a crossed-out figure, fecal matter, and plant life. Backos and Samuelson (2017) and identified that children meeting criteria for PTSD tended to draw figures with negative or neutral facial expressions. In the current study, four of the children drew child figures with negative facial expressions and two children drew figures without facial features.

Indicators of post-traumatic symptoms in the projective drawing literature, and the expressions of these features in the drawings of the current study parallel symptoms of post-traumatic stress disorder (Rodriguez, Steinberg, & Pynoos, 1999; King, Solomon, & Ford, 2016). Separation between figures could be interpreted as representing avoidance of reminders of the traumatic events, or of stimuli that previously brought joy or pleasure. Negative or neutral facial expressions could represent restricted affect, or emotional experiences associated with angry outbursts. While individual content of FETCH drawings and narratives vary across participants, representations of post-traumatic symptoms are common throughout and provide context for the overall analysis of drawings.

**Engagement in Therapy.** When asked to reflect on their child’s experiences working with the therapy dogs, the mothers’ tended to describe the treatment in positive terms. Mothers reported that they were initially hesitant to enroll their children in therapy. Bonnie, whose two daughters participated in therapy admitted that she was, “worried at first,” about enrolling her children in therapy but, “got more comfortable with the idea” when her daughters showed enthusiasm about attending their therapy sessions. Sasha, whose daughter received therapy,
stated that before this experience, she, “thought you had to be crazy to go to therapy”. Julia, who had one son that participated in therapy, also shared that while she was initially unsure about whether therapy could help, her son, “had been through a lot” and she was willing to try it because she knew her son liked dogs.

Mothers discussed the role therapy played in meeting the needs of their children. Jeana, who had one daughter enrolled in therapy, shared that while in the shelter, she, “didn’t always have the energy to listen” to her daughter because she was so tired. Jeana credited therapy with meeting her daughter’s emotional need to be heard. Echoing this sentiment, Sasha shared that she, “was glad [her children] had a place to talk about whatever they were feeling, big or small.” Overall, the mothers identified that their children learned to express emotional experiences in therapy. Bianca, who had three children in therapy, shared that her daughter learned to talk about, “why she is coming home [from school] so upset.” Similarly, Bonnie remarked that she was, “glad [her daughters] got to speak about their feelings” in therapy.

On the role that the dog played in therapy, mothers indicated that their children looked forward to sessions when the dog was present. Sasha, recalled that her daughter and son, “both liked [the dog], and they miss him a lot.” Bonnie shared that her daughters enjoyed spending time with the dog, who she felt, “helped [her daughters] feel safe sharing feelings.” Bianca shared that she understood why the children liked working with the therapy dog, and posed the question, “who doesn’t like a cute little dog?” Naomi discussed the impact that the therapy dog’s relationship had on the family, she “actually got a dog after [leaving the shelter] because [he children] loved [the therapy dog] so much.” Jeana expressed gratitude for the experience, as her daughter, “had not spent time with dogs before”

Mothers’ willingness to involve their families in therapy is significant, particularly given
the research on utilization of mental health services among homeless families. While up half of homeless children meet criteria for a mental health diagnosis, these children are significantly less likely than low-income, housed peers to enroll in ongoing psychotherapy programs (Park, Metraux, Culhane, & Mandell, 2012). Similar to individuals in other highly traumatized populations, homeless youth tend to have high “no show” rates for therapy appointments; for many provider agencies, this results in cancellation of services (Thompson, McManus, & Voss, 2006). The transient nature of this population accounts for some barriers to accessing mental health treatment, including inadequate transportation and frequent changes in contact information (Brumley et al., 2010). However, even services provided within the shelter environment report high drop-out rates (Lynch, Wood, Livingood, Smotherman, Goldhagan, & Wood, 2015). While several barriers exist that impede upon homeless families’ participation in mental health treatment, participants in the current study described AAPT, and particularly children’s contact with therapy dog, as a positive experience and a motivating factor for families to participate.

Case Vignette: Smith Family

The Smith Family, headed by Bianca, spent several months in the shelter following an incident of abuse against Bianca by her boyfriend, Gregory. The family was living in Gregory’s home, and he was the primary breadwinner. Gregory had a history of verbal and physical abuse against Bianca. Bianca and her five children went to a hospital Emergency Room and spent the night outside while a social worker assisted them in finding temporary shelter in a local motel. When asked about family support, Bianca shared that she does have siblings, but she disclosed that there had been a cutoff in her relationship with her siblings, and did not share further.

1 All participant surnames and first names have been replaced with pseudonyms to preserve confidentiality
information. It took several weeks for there to be an opening in one of the city shelters; Bianca and her children spent this time moving between friends’ homes and motels. During this period of time, Bianca learned that she was pregnant with her sixth child. She was approximately eight weeks pregnant when she and her children entered the shelter.

Her children started a new school in the neighborhood of the program. Legally, the Smith children would have been able to stay at their previous schools. However, these schools were located on the other side of the city, and the distance would have proved prohibitive for the Smith family to continue to attend. For the Smith children, this was the fifth year that they had started a new school. Allie, Bianca’s oldest child, left the shelter after several weeks to live with her father, William, and return to her previous high school. While Bianca was upset by Allie leaving, she honored Allie’s decision. The family’s initial involvement in therapy began when Felice began to struggle behaviorally in this new school. Ultimately, three of Bianca’s children

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*Figure 2. Smith Family Genogram*

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received therapy during their stay in emergency housing - Dot (age 11), Felice (age 10), and Gregory (age 8). Each of these children also agreed to participate in the study, and Bianca agreed to participate in a parent interview.

**Felice, Age 10.**

*Developmental History.* Felice was the first of the Smith children to enroll in therapy. Since entering the shelter and beginning her new school, Felice became involved in several physical altercations with classmates. Bianca reported that physical aggression was a new behavior for Felice, and expressed significant concern about her well-being. In an initial appointment, Bianca shared that Felice was born a few weeks premature and weighed five pounds at birth. She gained weight quickly, and met developmental milestones at the following ages; she crawled at eight months, walked alone at ten months, and completed toilet training at approximately two years. Bianca estimated that Felice began speaking at eighteen months and spoke in full sentences at approximately two years.

**Therapy Referral.** Apart from the behavioral acting out that prompted the therapy referral, Felice had not faced any disciplinary action in school. Bianca shared that Felice had attended five schools in five years, and that previous teachers had described her as quiet and a good student. Bianca also expressed concern that Felice might have experienced bullying at school. Bianca did not report any significant physical health problems, and described Felice’s primary issues as “extreme anger” and “bad nerves.” Bianca also noted that Felice struggled with self-esteem and often took on a parental role towards her siblings and her mother, despite being a middle sibling.

**Trauma History.** In an initial therapy session, Felice was administered The Cameron Complex Trauma Interview [CCTI] (Boyle, Solomon, Ford, & Gil, 2014). In the interview,
Felice disclosed several potentially traumatic experiences. She described a trip to the emergency room, at age three, following her hitting her head on a glass table while playing. Both Bianca and Felice reported that Felice was approximately three years old at the time and received several stitches. In the CCTI, Felice also disclosed that she had witnessed community violence in a previous neighborhood, and that a close family friend had died suddenly. Felice did not disclose witnessing violence against her mother at the time of the CCTI, but Bianca disclosed that Felice was present for several violent incidents. Felice reported several post-traumatic symptoms, including difficulty focusing, episodes of dissociation, and unprovoked mood swings. Felice also reported feeling that she had to care for the adults and other caregivers in her life.

_Treatment History._ Felice participated in fourteen therapy sessions, and the therapy dog was present for at least five sessions. Felice also made occasional visits to the therapist’s office to interact with the therapy dog on days when she did not have an appointment. Initially, Felice’s interactions with the therapy dog focused on relationship-building and on caregiving tasks. Felice often created stories using sand tray miniatures, and would ask for the therapy dog to sit on the couch while Felice told the dog her stories. Felice spoke directly to the dog. Initially, Felice’s stories were about pleasant events such as a family taking a trip to the beach or going out for ice cream. Later in therapy, Felice told stories with themes of violence and trauma. In one story, Felice shared that her characters set a fire and were going to jail. Felice watched the therapy dog’s face while telling this story.

_Parent Interview._ When interviewed about Felice’s experiences in therapy, Bianca characterized Felice’s new coping skills to deal with angry outbursts as very helpful. Bianca shared that, since having therapy, Felice was better able to verbally identify the sources of her anger. At the time of the interview, Bianca shared that she is considering finding a therapy
agency in their new neighborhood to help Felice cope with life transitions. In reference to the therapy dog’s involvement, Bianca stated that Felice looked forward to therapy because of the dog. Bianca liked that Felice could pet the dog while she was telling stories, and believed that petting the dog was comforting for her daughter. Overall, Bianca characterized Felice’s work with the therapy dog as a positive experience.

**FETCH.** In her FETCH drawing (Figure 3), Felice primarily used the brown crayon (though she began the drawing using a purple crayon). Her picture included a dog and a child, who Felice identified as a girl. Felice included long hair and clothing on her girl figure. The dog has four legs and a tail, but no ears. Both the girl and the dog have smiling facial expressions. There were no additional figures or scenery in the drawing. Felice’s drawing occupied the bottom right-hand corner of the page, and filled less than twenty percent of the page. Felice spent the most time on the dog figure; she colored the figure using a circling hand motion.

**Developmental Aspects of Drawing.** Felice’s drawing includes some elements that would be expected developmentally; the proportions and level of detail in the girl figure suggest refinement of a style of representing a girl figure. Otherwise, elements of the drawing are more rudimentary than what would be expected for her age. She did not include a baseline at the bottom of the page or other elements of scenery, which is more consistent with drawings by children ages 7 through 9 (Malchiodi, 1998). Lack of scenery and imaginative content is also consistent with a history of trauma (Backos & Samuelsen, 2017).
Emotional Aspects of Drawing. The emotional content of the picture appears to be in conflict; the figures appear to be smiling, but the single, dark color may suggest negative emotionality (Malchiodi, 1998). The drawing does not include any background or context, and there are no grounding or foundational lines at the bottom of the page. This might also suggest some negative emotionality, including feelings of loneliness or isolation. Felice’s beginning the drawing in one color and then switching to brown for the remainder of the process might suggest some hesitance or ambivalence to share emotional content.

FETCH Story. In the narrative accompanying the FETCH drawing, Felice described a dog and a girl meeting for the first time. At the moment depicted, the girl had been standing somewhere, and the dog approached the girl. The dog “rubbed up” against the girl’s leg. Felice then changed the beginning of her story, and stated that the girl was walking to an ice cream shop and then she saw the dog. The dog had no leash and presumably no owner. The girl noticed that the dog looked hungry and decided to buy dog food for the dog instead of the ice cream for her that she planned to buy. The girl then took the dog to the veterinarian to make sure that the dog was healthy and the girl’s mother allowed the girl to keep the dog. Felice stated that the dog and

![Figure 3. Felice Smith FETCH Drawing](image-url)
girl “lived happily ever after.”

**Salient Themes.** Felice’s drawing revealed several discrepancies in her developmental trajectory and relational patterns. The discrepancy between Felice’s chronological age and the developmental level of her drawing could be the result of her exposure to trauma, or of the several educational disruptions that she faced. Similarly, the emotional content of the drawing appears to be in conflict; the drawing is sparse but both figures are drawn with smiling faces. This is reminiscent of the discrepancy between Felice’s aggressive outbursts in school and generally calm demeanor. The shading of the dog figure could have significance; according the Kinetic Family Drawing manual, shading part or all of the figures is common among children who are diagnosed with anxiety (Burns, 1982). The circling motion could also have been an attempt to create the appearance of texture. This feature creates an additional level of discrepancy or uncertainty to the drawing, as the shading could suggest technical sophistication or the manifestation of anxiety.

The FETCH narrative evoked several themes of child development and attachment. Erikson’s (1997) school-aged psychosocial conflict of industry versus inferiority is present in Felice’s description of the girl figure as very helpful; this is in conflict with her initial statement that she was not good at drawing when prompted to draw the FETCH. In Felice’s story, the girl did not know the dog prior to the events of her story. The dog belonged to someone else. In an attachment framework, this might suggest that the girl lacks of secure base from which to explore (Jalango, 2015). Furthermore, Felice made several references to the physicality of the dog figure. She described the dog as “fuzzy” and described the initial meeting as the dog “rubbing up” against the girl. Seeking physical affection might suggest secure attachment; the notion of physical affection on first meeting might be more consistent with a reactive or
disorganized attachment (Bowlby, 1977). Alternately, the immediacy of the physical contact might reflect the interpersonal trauma Felice witnessed in her family.

Overall, the caregiving relationship between the girl and the dog is central to Felice’s FETCH story. Feeding the dog and bringing the dog to the veterinarian reflect the attachment concept of expecting protection (Jalongo, 2015). It is notable that the girl is caring for the dog, rather than the being cared for. In her parent interview, Bianca noted that Felice often took on a parental or caregiving role, despite being one of the younger siblings. The attachment roles might be reversed, but the girl’s (and Felice’s) caregiving responsibility reflects fulfillment of being industrious and therefore combating feelings of inferiority.

**Dot, Age 11.** After Felice started meeting with the therapist, Bianca requested that two of her other children begin therapy. Bianca shared that she wanted Dot, Felice’s older sister, to have a place where she felt safe sharing her feelings. Bianca felt that the transitions the family experienced in the past year might be impacting Dot, even if Dot was not expressing this in the way that Felice was.

**Therapy Referral.** In the intake session, Bianca shared that her pregnancy with Dot had been healthy and that Dot weighed seven pounds at birth. Bianca breastfed Dot for six months, and did not report any feeding or other health concerns during Dot’s first year of life. Bianca shared that Dot met developmental milestones at the following ages; she crawled at seven months, walked at 11 months, and spoke in full sentences at two years of age. Dot completed toilet training at two years of age and Bianca reported that Dot was the easiest of her children to train. When asked about tantrums, Bianca shared that Dot had occasional tantrums at two years, but was easily calmed if Bianca “talked through” the tantrum with Dot. Bianca did not report any difficulty disciplining Dot, and shared that Dot was very successful academically and socially,
despite the family’s many moves and school changes.

**Developmental History.** In the intake session, Bianca shared that her pregnancy with Dot had been healthy and that Dot weighed seven pounds at birth. Bianca breastfed Dot for six months, and did not report any feeding or other health concerns during Dot’s first year of life. Bianca shared that Dot met developmental milestones at the following ages; she crawled at seven months, walked at 11 months, and spoke in full sentences at two years of age. Dot completed toilet training at two years of age and Bianca reported that Dot was the easiest of her children to train. When asked about tantrums, Bianca shared that Dot had occasional tantrums at two years, but was easily calmed if Bianca “talked through” the tantrum with Dot. Bianca did not report any difficulty disciplining Dot, and shared that Dot was very successful academically and socially, despite the family’s many moves and school changes.

**Trauma History.** Bianca shared that Dot was very close with a grandmother and great-aunt, who both died of cancer within the past year. Bianca also disclosed that Dot may have witnessed and overheard physical and emotional abuse that Bianca endured from Gregory Senior. In her trauma assessment, Dot identified witnessing physical violence at home and at school as her most distressing events. She denied having many symptoms related to witnessing violence, but shared that she felt scared and unsafe when violent incidents occurred. When asked about how she handled these emotions, Dot explained that she would think about happy memories until her negative emotions went away. This is consistent with Bianca’s observation that Dot might not be expressing her negative experiences.

**Treatment History.** Dot met with her therapist six times. Her therapist, who was not the therapist who implemented AAPT, offered directive play therapy. The therapist introduced Dot to play-based activities focused on building coping skills. Per her therapist’s notes, Dot expressed
the most interest in completing art projects and sensory-based activities. Dot’s therapist introduced some deep breathing techniques and helped Dot create a “Mind Jar,” a mason jar filled with glitter and water, in order to introduce basic mindfulness concepts. Dot also enjoyed playing structured board games and her therapist noted that Dot really enjoyed winning the games.

While the therapy dog was not integrated into Dot’s therapy sessions, she showed a strong interest in spending time with the dog and would often visit the therapy office after school with her siblings. Dot primarily engaged in care taking behaviors with the dog, and often asked questions about grooming and bathing the dog. The therapist taught Dot how to brush the therapy dog; subsequently, Dot would request to brush the dog’s fur during every visit. With some guidance, Dot learned how to identify when the dog’s body language indicated comfort or discomfort. Dot expressed pride in her newfound ability to communicate with the dog, and taught her younger siblings how to greet the dog in a way that was sensitive to the dog’s needs.

**FETCH.** In her FETCH drawing (Figure 4), Dot did not use any of the crayons provided. She instead chose to use a black ink pen that was in the room where her interview was conducted, but not explicitly offered to her as a drawing tool. The drawing contains two figures - a dog and a child, that Dot identified as a girl. Both figures are located in the center of the page, and there are no other figures or background images. The girl and dog are connected by a leash, and the dog has a curly tail (it is important to note that the therapy dog was a pug mix and had a curly tail). The girl is a stick figure and has no body features beyond arms and legs. The girl’s face has a mouth, eyes, and eyebrows but no nose. Dot drew hair on the girl figure, and the hair is roughly the same size as the girl’s entire body.
Developmental Aspects of Drawing. Like her sister, Dot’s drawing was rudimentary compared to what one might expect for her age. There were limited details included in the figures and the picture lacked depth and other context cues (Malchiodi, 1998). However, the detailing of the hair, and the large size relative to the girl figure is typical for adolescent and pre-adolescent girls (Burns, 1982). It is worth noting that Dot might not have been drawing as she normally would, due to the unnatural environment of data collection.

Emotional Aspects of Drawing. Like her sister, Dot’s drawing takes up minimal space on the page and uses limited color. The girl figure’s facial expression is unclear and appears to include a wide-open mouth and eyebrows. Despite the lack of context, the placement of figures could have a positive or hopeful connotation. The girl is facing the dog figure, who is connected to the girl using a leash. The physical closeness of the dog and girl could represent emotional closeness, or proximity seeking.

FETCH Story. Dot’s story focused on the dog and girl becoming separated during a game of fetch. Dot explained that the dog and girl were in the park playing, and then the dog saw some other dogs and ran away from the girl to play with the dogs. The dog got lost and then became stuck in a bush. The dog was very scared when he was stuck in the bush, and the girl was
very scared that she couldn’t find her dog. After searching the whole park, the girl found the dog and they went home together. At this point, Dot shared that the dog belonged to the girl and that they were best friends and “inseparable.” Dot described some of the activities that the dog and girl do together, including going on vacation to Miami. Dot entitled her story, “The Dog Best Friend.”

**Salient Themes.** According to the K-F-D manual, the central location of the image could suggest reasonable emotional security, or rigidity in interpersonal relationships. The small size of the drawings could reflect feelings of inferiority, inadequacy, or withdrawal tendencies (Burns, 1982). Within the context of Dot’s case history, the competing themes within the location and relative size of the figures might be representative of the intense emotions that the client feels but does not outwardly express. Dot’s use of an ink pen might have significance. While Malchiodi (1998) notes that the choice of drawing tools could reflect more about the materials provided than the child, Dot used a drawing instrument outside of what was provided. Dot’s use of a pen and her small sketch could be the result of ambivalence about the art exercise, or ambivalence about the content of the drawing she created. Selection of a single color may also signal an attempt to focus on the details of the drawing for the purpose of ensuring accuracy (Malchiodi, 1998).

Dot’s story, and the notion of playing fetch, aligns with the concept of rapprochement crisis. Like the infant *shadowing* and *darting away*, the dog expresses the same amount of excitement running away from their companion and running back towards their companion (Mahler, Pine, & Bergman, 1975). Dot made more explicit reference to the rapprochement crisis through the narrative of the dog running away from the girl and then returning to the girl. The narrative also touches on themes of attachment; Dot referred to the physical closeness between
the girl and dog while they slept (Bowlby, 1977). Dot also described their relationship as unconditional; they spent time together even when “she is sad, happy, or angry.” This is consistent with the notion of a secure attachment, and suggests faith in the relationship she shared with the dog.

**Gregory, Age 8.**

*Therapy Referral.* Gregory, the younger brother of Dot and Felice, also received therapy. Bianca initially referred Gregory to therapy because he showed poor frustration tolerance and because he had a difficult relationship with his father. Bianca also expressed concern about the impact that the knowledge of the abuse that his father inflicted on her might have. Bianca shared that Gregory was generally happy, and had positive relationships with his peers and the adults in his life. She did not report any major disciplinary or academic issues in school.

**Developmental History.** Bianca shared that her pregnancy with Gregory had been healthy; Gregory was just over eight pounds at birth and had no reported issues feeding. Bianca was diagnosed with postpartum depression following Gregory’s birth. This also coincided with the beginning of the abusive relationship between Bianca and Gregory Senior. According to Bianca, Gregory met developmental milestones at the following ages—he crawled at eight months and walked on his own at one year. She could not recall when he said his first words, but reported that he completed toilet training at two years.

**Trauma History.** In his CCTI trauma assessment, Gregory identified witnessing violence at home and at school as his most distressing event. He reported experiencing difficulty sleeping, hypervigilance, and impairment in behavioral control. Bianca and Gregory both disclosed that the strained relationship between Gregory and his father was distressing to Gregory. Gregory was privy to some of his parents’ violent altercations, and likely was aware of the abusive dynamic in
their relationship. Bianca shared that she hoped to protect Gregory from knowledge of his father’s violent tendencies, but acknowledged that Gregory was perceptive and was had an understanding of his parents’ domestic violence relationship.

_Treatment History._ Gregory participated in ten play therapy sessions, and his clinician primarily used a non-directive approach. Initially, Gregory hesitated to explore the playroom and the clinician focused on supporting the client to build comfort and confidence to engage in self-directed play. After his initial session, Gregory showed preference for playing with costumes and other props; he assigned his therapist characters to play. Often his play themes involved a divide between “good guy” and “bad guy” characters, with Gregory switching between roles. Often, he would express physical frustration through punching the bop bag, compose himself, and then tell the therapist that he was “just kidding,” and not actually angry or frustrated. The therapist shifted the focus to helping Gregory tolerate his own emotions and express those emotions through play therapy.

Like Dot, Gregory did not have the therapy dog integrated into his therapy sessions, but showed a strong interest in spending time with the dog. Most days after school, Gregory would knock on the therapy office door and ask if the dog was present. For a few minutes each week, Gregory spent time with the dog. With some support, Gregory learned how to cue to the dog to sit, speak, lay down, stay, and high five. Gregory expressed an interest in learning about dog training, and the therapist taught him some of the basics of clicker training. With support, Gregory participated in some training of the therapy dog to work on a new cue, “nose,” in which the dog rolled a basketball across the floor with his nose. Gregory expressed pride in the dog, and suggested that the dog join the “doggie NBA” on the basis of knowing this trick.

**FETCH.** In his FETCH drawing (Figure 5), Gregory used three crayon colors - green,
red, and brown. He included two figures, a dog and a child, which Gregory identified as a boy. The dog and boy are connected by a leash, and both figures have word bubbles above their heads reading, “hey.” There is a green and red line sketched along the top of the page. Gregory drew the boy figure in red, and included a head, legs and arms. Each arm has five fingers protruding from the wrists, but without hands. The face includes a mouth with a smiling expression and two open circles for eyes. The leash is drawn in green, and the dog is drawn in red and brown. The dog’s body was drawn with a circling motion in brown, and there are several open circles along the body. The dog’s face includes two eyes and a square nose, and triangle-shaped ears.

![Figure 5. Gregory Smith FETCH Drawing](image)

*Developmental Aspects of Drawing*. While Gregory did not include scenery, his sketching at the top of the page could be interpreted as a baseline. This is to be expected from children in his age group (Malchiodi, 1998). According to the K-F-D, the length of the boy figure’s legs is significant. It may suggest a need for autonomy, or feelings of grandeur (Burns, 1982). The figure has both arms and legs, but lacks a torso. Typically, rudimentary figure drawings such as this are typical of children in the pre-school age (Malchiodi, 1998). As with Felice, Gregory might be behind in some areas due to the family’s frequent moves and accompanying school changes.
*Emotional Aspects of Drawing*. Both the dog and child figures are facing forwards, and the child has a smiling face. While the dog does not have a mouth or discernible facial expression, the word bubbles from both figures suggest an upbeat, positive tone. The figures are attached by a leash, which suggests a relationship between the dog and child. In the context of Gregory’s narrative, the relationship has a positive connotation. Furthermore, the choice of bright colors - green and red - also suggests a positive emotional tone.

*FETCH Story*. In his narrative, Gregory started the story with the dog running away from the boy. As the story continued, Gregory included additional details about the boy and dog’s relationship. The dog and boy live together, and the boy was walking the dog when the dog got loose from the leash and ran away. The dog was running very fast and almost got hit by a car, but ultimately was not hit. The boy was crying, first because he thought the dog would be angry for failing to protect him, then because he was scared that the dog would be hurt. At the end of the story, the boy found the dog and put the leash back on. Gregory stated that the boy felt happy when he found the dog.

*Salient Themes*. In Gregory’s drawing and narrative, several themes of attachment are present. The boy and dog figure are connected using a leash. This could indicate a close bond, as the figures are directly touching, or perhaps a tentative bond, as the physical contact requires a leash. Gregory told a story about the dog running away and the boy searching for the dog. The back and forth nature of their interactions resembles the patterns of *shadowing* and *darting away* that children show in early childhood (Mahler, Bergman, and Pine, 1975). Furthermore, the overall narrative of the story evokes the attachment concept of expecting protection. The dog was almost hurt, but the boy found the dog in time. When the dog ran back to the boy, this resembles the attachment concept of proximity seeking.
Case Vignette: Jones Family

Sasha and her five children entered the shelter following several years of housing instability. Randall, the children’s father, lived on and off with the family and had been incarcerated several times. Sasha described Randall as her husband “legally,” but stated that their relationship was not a supportive partnership. Six months prior to entering the shelter, Sasha separated from Randall and struggled to find a stable living arrangement. She spent some time living with her sisters, but ultimately sought housing through the city shelter system. After a brief stay in a temporary shelter, Sasha and her children were placed in the family shelter where the study was conducted. Sasha’s two oldest children received therapy services outside of the shelter, and her youngest child, Nan (age 6), participated in Animal Assisted Play Therapy™ with the onsite therapist. Nan’s brother Charlie (age 9) participated in one family session, and made several recreational visits to the therapy dog. Both Nan and Charlie agreed to participate in the
study, and Sasha participated in a parent interview.

**Nan, Age 6.**

*Therapy Referral.* Sasha made initial attempts to enroll her sons Randy and DeShawn in therapy due to frequent instances of the boys returning to the shelter after their curfew. Sasha met with the therapist but neither boy agreed to enroll in the therapy program. Several weeks later, Sasha contacted the onsite therapy service and explained that her daughter Nan had an incident at school that might require Nan to see a therapist. In the intake session, Sasha explained that a male classmate exposed his genitals to Nan. Since the incident, Nan had been refusing to talk while in school. In the intake session, Sasha shared that she was concerned about Nan because she was often passive around her peers and did not initiate play. Sasha also shared that Nan had thrown tantrums daily since the family entered the shelter, a behavior she had not exhibited since she was four. Sasha identified other behaviors of concern, including Nan’s occasional shoplifting of lipstick and other cosmetics. Sasha explained that she had been a victim of sexual assault when Nan was an infant, and that Nan had been present for the assault. Sasha and Nan’s therapist discussed the possibility that the exposure incident in school might have triggered some post-traumatic symptoms associated with this pre-verbal trauma memory.

*Developmental History.* Sasha reported that Nan was born with ventricular septal defect (VSD), a small hole in the wall between the two lower chambers of her heart. While the VSD was small enough not to require surgery, Nan spent time in the NICU following her birth. Sasha was unable to breastfeed Nan, though Nan met milestones for weight gain and did not experience any subsequent health problems during the first year of life. According to Sasha, Nan met developmental milestones at the following ages; she crawled at six months and took her first steps at ten months. She said her first word at five months, and spoke in full sentences at two
years and six months old. Nan did not have any difficulty toilet training, and was reportedly toileting independently at eighteen months. This is younger than would be developmentally expected; it was unclear from the treatment record whether Nan met this milestone early or Sasha misremembered this.

**Trauma History.** In the CCTI, Nan identified her classmate exposing his genitals, and the subsequent child protective services investigation as the most distressing potentially traumatic event. She also reported her father’s incarceration and witnessing community violence as other potentially traumatic events. She reported experiencing several symptoms associated with post-traumatic stress including hypervigilance, intrusive thoughts, and difficulty regulating emotions. She reported that these symptoms began several weeks after her classmate exposed his genitals to her. Sasha and the therapist discussed the possibility that some post-traumatic symptoms from earlier traumas were reignited with this most recent incident.

**Treatment History.** Nan participated in nine play therapy sessions with the therapist trained in AAPT, and the therapy dog was actively involved in her sessions. Nan’s therapist implemented a combination of child-centered and directive play therapy. In child-centered play, Nan expressed preference for playing in the toy kitchen, and would pretend to cook elaborate meals for the therapy dog. In a family session, Nan played *Feelings Candyland* (in which players discuss a different emotion for each color on the game board). She requested to play the game again in each subsequent session and shared that she also liked to play the game with her family outside of sessions. With the therapy dog, Nan showed some initial hesitation and explained that she was nervous around the dog. The therapist asked whether Nan had concerns about working with the dog, and Nan shared that she was not usually scared of dogs, but something about the therapy dog made her nervous. Nan ultimately became comfortable around the dog, and took
pleasure in brushing the dog and cueing the dog to do some tricks. Nan also enjoyed showing her family some of these tricks.

In her play therapy sessions, Nan explored themes of identity and role development, as well as dichotomies such as ‘good’ versus ‘bad.’ For example, she used a scarf in the dress-up area to fashion a hijab, a traditional Muslim head scarf, and portrayed one of the other mothers in her shelter. Nan’s family was Christian and Sasha shared that Nan played in this manner outside of therapy, and expressed concern that Nan might offend one of the other shelter residents. In a discussion with Nan and Sasha, the therapist asked about Nan’s association with the hijab. Nan explained that the Muslim women in the shelter were so friendly and nurturing, that she wanted to look like them and wear their clothing. Clinically, Nan’s association of the other residents’ identity markers with personality traits mirrored her own search to distinguish between safety and danger.

**Parent Interview.** During the research interview, Sasha shared that Nan started a new school as result of a complaint Sasha filed following the exposure incident. Nan was performing well in her new school and already made some new friends. By Sasha’s report, therapy was a positive experience for Nan and Nan built self-confidence through her work with the therapy dog. Sasha shared that Nan continued to play Feelings Candyland with her brother and often talked about the therapy dog. Sasha shared that her impressions of therapy prior to Nan’s experience were negative, and that the she assumed that therapy was for people who were “crazy.” Sasha shared that Nan built several important coping skills during therapy, and built an important relationship with the therapy dog.

**FETCH.** In her FETCH drawing (Figure 7), Nan used brown, purple, and blue crayons. She initially asked whether she could include a cat in the drawing, and included three figures in
the drawing - a dog, cat, and child (which she identified as a girl). Each figure was surrounded by a square, and each figure had a word bubble with a single word in it. Nan drew two vertical lines that divided the page into three columns; each column included one square and figure. As Nan told her FETCH story, she wrote the beginning lines of the narrative about each figure underneath the square.

![Figure 7. Nan Jones FETCH Drawing](image)

*Developmental Aspects of Drawing.* The figures in Nan’s drawing, with basic forms and minimal details, are representative of the pre-schematic stage in drawing (Malchiodi, 1998). In this stage, which occurs between ages five and six, children develop and refine their approach to drawing figures. Nan’s quick drawing of the dog, cat, and girl suggest that these are figures she draws often. The cat drawing was more detailed than the dog or girl, and includes facial features, a tail, and a small cushion to sit on. It might be that she frequently draws cats, and has developed a schema for this figure. The girl figure has no features on her body, and is missing hands and feet. Developmentally, hands and feet might be expected of children of Nan’s age and relative developmental level (Burns, 1982). Nan might be in the process of developing schema for drawing people, which suggests she is still progressing through the pre-schematic drawing phase.
Emotional Aspects of Drawing. In her story, Nan described each figure using one characteristic; the girl was happy, the cat was smart, and the dog was good at digging. The separate sections of Nan’s drawing, including the boxes around the figures and the lines dividing the page into columns, reflect the separate emotions and personality qualities in each figure. Scoring guides for many projective drawing tests liken physical distance between figures as a sign of emotional distance (Burns, 1982). Furthermore, Nan’s color choices might have emotional significance. The girl and cat – figures that she described as happy - have stories written in blue and purple crayon.

FETCH Story. Nan responded to the prompt by telling three individual stories, one about each figure. In the first story, the dog was named Tye and he was digging. Nan described Ty as very helpful, and explained that he was digging to find food. In the second story, Nan described the cat as very smart, and was digging to make a home in the ground. The cat built his home in the dirt, and people around him provided food for him to live. In the third story, the girl was happy and said “hi.” When asked if the girl was speaking to someone, Nan explained that even though each figure had its own story, the figures were standing near each other. Nan ended the story by explaining that the figures never met, but the girl tried to meet the cat and was unsuccessful.

Salient Themes. Most striking in overall appearance of Nan’s FETCH drawing are the divisions between the figures, and the separate written narratives accompanying each figure drawing. Some psychoanalytic scholarship suggests that children’s drawings can be interpreted as visual representations of defense mechanisms (Benveniste, 2005). Nan’s columns and boxes could evoke images of compartmentalization, the cognitive separation of conflicting ideas or emotions in order to avoid cognitive dissonance. Nan’s most recent traumatic event, her
classmate’s exposure of genitals, conflicts with her sense of school as a safe place. Her father’s history of incarceration conflicts with her experience of him as a reliable and trustworthy adult. The divisions in her drawing could reflect her attempts to cognitively reconcile these unconscious conflicts.

During the drawing process, Nan expressed pride in her ability to draw these figures, and in her writing ability. The notion of having pride in her actions aligns with Erikson’s (1997) school-aged conflict of industry versus inferiority. Because Nan and Sasha both described Nan’s feelings of competence and confidence following her work with the therapy dog, Eriksonian theory can be applied to the impact of the dog on the therapeutic process. Learning to work with the dog empowered Nan to build self-confidence, and in turn overcome feelings of inferiority. The figures in Nan’s FETCH story were active within their own environments; the cat and dog were digging in the dirt and seeking food and shelter. This storyline supports the importance Nan places on action and task-oriented growth and suggests that these areas of development hold importance for Nan’s safety and overall well-being.

Charlie, Age 9.

Therapy Involvement. Charlie did not participate in individual therapy while at the shelter, but was present for a family session with Nan and Sasha. Charlie and Nan shared a close relationship and, per Sasha’s report, Nan often taught Charlie about the games that she played in session. Charlie and Nan played Feelings Candyland in the session, and both children chose sand tray miniatures as game pieces. Charlie chose superhero figures, and chose a different superhero for each round of the game played. Sasha shared that Charlie enjoyed super-hero themed games and movies, and often identified as his favorite superheroes when expressing emotions. The therapy dog was present for the family session, and Charlie expressed a strong interest in
learning about the dog’s cues and behaviors. While Charlie did not have individual therapy, he made informal visits to the therapist’s office on days when the therapy dog was present. In these visits, Charlie learned how the therapy dog responded to cues, and expressed joy when he learned how to direct the dog to sit, stay, and give high five. After Nan’s last therapy session, Charlie visited the office and said good-bye to the therapy dog.

**Trauma History.** Because Charlie was not enrolled in individual therapy, there was not an individual case history completed. However, events in Nan’s history that impacted the entire family would also be considered part of Charlie’s trauma history. These include their father’s incarceration and witnessing community violence. It is also notable that Charlie was three when Nan was born and experienced her VSD diagnosis. The focus on his sibling during this critical developmental period could have detrimental effects.

**Parent Interview.** In discussing therapy, Sasha shared that both Nan and Charlie benefitted from the experience. Charlie enjoyed playing the games that Nan learned in therapy, and continued to play those games long after treatment had ended. She also shared that Charlie had increased his ability to express his emotions. Sasha also shared that Charlie would stop at the therapist’s office to check whether the dog was present almost every day after school. Since Nan’s therapy ended, Charlie did not seek therapy but Sasha shared that Charlie might be willing to see a therapist if a therapy dog was involved.

**FETCH.** Charlie’s FETCH drawing (Figure 8), includes three figures - a dog, a child, and a second child that is crossed out. The crossed-out child is drawn in pen, while the other figures are drawn in crayon. Overall, Charlie used five crayon colors and included a yellow sun, blue sky, and green grass along the bottom of the page. Charlie used most of the page to complete his drawing, with the figures taking up less than a quarter of the page. Charlie wrote the title of his

![Image](image.png)

*Figure 8. Charlie Jones FETCH Drawing*

*Developmental Aspects of Drawing.* Charlie’s drawing includes some details consistent with the schematic stage of drawing, in which children further refine their approach to drawing common items. This stage typically occurs between age seven and nine; characteristics typically found in schematic stage drawings include a grounding line and variation in color (Malchiodi, 1998). While most of Charlie’s drawing is consistent with what is expected developmentally, there are some discrepancies. The child figure lacks details such as feet and hands; this is in contrast to the detailed face and hair included in the same figure. The dog includes some facial features and details in the ears, but lacks a tail and details in the legs.

*Emotional Aspects of Drawing.* Some projective drawing scoring guides relate the ways that arms are drawn to the child’s overall connection to their environment (Burns, 1982). The lack of hands and feet might suggest that Charlie feels disconnected from some component of the environment, or lacks mastery and control over fine motor functioning. Overall, the appearance of the crossed-out figure, including the contrast of the pen with the other figures being in full color. The figure and the lack of conversation about that figure might reflect this disconnection or perhaps some shame or embarrassment.
**FETCH Story.** Charlie told a story about the dog and child figure, and did not include the crossed-out figure in his story. The child, who Charlie identified as a boy, was playing with the dog at the park. They played fetch with a ball or a stick, and then went back to the boy’s house when they got tired. Charlie explained that the dog lived with the boy, and that the boy found the dog in the park one day when the dog was lost. The boy brought the dog home and the dog lived with the boy’s family. Charlie’s story ended with the boy eating a hamburger and the dog eating some dog food.

**Salient Themes.** Charlie’s story and drawing have a completeness about them. The story has a clear beginning, middle, and end; the picture has filled the entire page. Overall, Charlie’s drawing and the accompanying story represent an appropriate developmental level for his age and educational history (Malchiodi, 1998). The figures in the drawing, the dog and both children, are drawn in proportion to the rest of the picture. The tone of the drawing, including figures in close proximity and bright-colored scenery, is hopeful. There is a disconnect between the amount of detail included in the child figure’s face and hair, and the lack of detail in the child’s body, arms, and legs. This could represent a discrepancy between the client’s self-image and the way that his family perceives him.

It is significant that Charlie’s crossed-out figure is located in the center of the drawing. He drew the figure first, crossed it out, and then created his drawing around it. Charlie experienced many of the same traumatic events as Nan, but receives less focus than his siblings. Charlie’s older siblings have exhibited externalizing behavior, and Nan has experienced some medical and interpersonal trauma. While he has not verbalized it, Charlie might have some unmet emotional needs and feelings of inadequacy related to the focus on his siblings. The dog is facing the crossed-out figure and has a positive facial expression. This might suggest that Charlie
sees the dog as a supportive presence, regardless of how other people perceive him. This is consistent with the FETCH story, in which the dog and child share a mutually enjoyable relationship.

**Case Vignette: Martin Family**

![Figure 9. Martin Family Genogram](image)

Bonnie and her two daughters, Lena and Janet, moved in to the shelter following a violent incident with Tye, Janet’s father. Bonnie and her daughters had been living with Tye for several years, and Tye’s violence towards Bonnie had escalated in the months prior to the family entering the shelter. Both daughters witnessed physical and verbal abuse that Tye inflicted on Bonnie. Prior to her relationship with Tye, Bonnie had a long-term relationship with a man named Steven, who is Lena’s biological father. Bonnie lived with Steven for approximately one year after Lena’s birth, and Steven continued to be a presence in Lena’s life after Bonnie and Steven separated. Janet developed a rapport with Steven and considered him to be her step-
father. Steven entered a relationship with a woman named Kylie, and Kylie had occasional
contact with Lena and Janet. Several months prior to Bonnie’s shelter stay, Steven was arrested
for assaulting a friend and would be incarcerated for at least three years.

While both Janet and Lena were enrolled in therapy, Janet was involved in therapy first.
Bonnie expressed concern about the impact that Tye’s abuse and Steven’s incarceration had on
the girls’ emotional well-being but was particularly concerned that Janet might react strongly to
witnessing her biological father act out violently. She made efforts to maintain consistency in the
girls’ lives while the family stayed in the shelter. Bonnie continued to transport her daughters to
the school they attended in a neighboring city. The family traveled for over an hour each way,
and took multiple trains and buses to school each day. The school served as an important
component of the family’s support system, and Bonnie was able to find a job in the school’s
cafeteria. The job helped Bonnie to achieve self-sufficiency and allowed Bonnie to keep her
children in the school.

**Janet, Age 6.**

*Therapy Referral.* Bonnie enrolled Janet in therapy after her teacher reported that Janet
was acting out aggressively against her peers. In the intake session, Bonnie shared that since
entering the shelter, Janet began wetting the bed. Bonnie shared that she was upset at first and
believed that Janet might be ill or perhaps purposely bedwetting. In the intake session, the
therapist provided some psycho-education about bedwetting as a behavioral reaction to stress and
anxiety. Bonnie and the therapist identified several therapy goals including increasing emotions
identification, developing coping skills, and processing her past trauma.

*Developmental History.* The therapeutic services intake form, which included
information about developmental history, was not available for this participant.
**Trauma History.** In her CCTI, Janet identified several potentially traumatic events including her stepfather being arrested, witnessing community violence, and being robbed by one of her classmates at school. While Janet did not discuss her parents’ domestic violence relationship during the CCTI, she later explored the dynamic through her play therapy. Janet reported several symptoms potentially indicative of post-traumatic stress, including somatic symptoms including headaches, difficulty finishing tasks, hypervigilance, and nightmares. Janet initially denied bedwetting during the CCTI, but later acknowledged that she wet the bed three times per week. Janet expressed initial embarrassment about wetting the bed, but ultimately was relieved when the therapist explained that many children in new or stressful situations experienced this symptom.

**Treatment History.** Janet participated in thirteen play therapy sessions, eight of which were canine-assisted. Janet worked with the therapist who is trained in AAPT and participated in some family and joint sessions with her mother and sister. In child-centered play, Janet often worked in the sand tray and selected monster and insect-themed miniatures to enact battle scenes. Her play themes included conflict and violence, as well as secrecy. In other sessions, Janet brought sand tray miniatures into the dollhouse and introduced her family members by comparing them to the miniatures. Janet primarily chose Disney princesses and superhero figurines to represent family members; she often chose Tiana from ‘Princess and the Frog’ to represent her. In the dollhouse activity, Janet introduced some of the abusive dynamics in Bonnie’s and Tye’s relationship, and also the interactions that Steven had with both she and her sister. She often enacted physical fights with the miniatures representing Bonnie and Tye. Janet shared in these sessions that Steven often included Janet in the activities, such as going to the zoo or park, that he planned to do with Lena.
With the therapy dog, Janet took pleasure in learning the tricks that the dog was able to perform. In particular, Janet enjoyed giving the dog “high five,” and instructing the dog to roll a basketball with his nose. However, Janet expressed frustration when the dog did not act in the way that she expected. For example, on a day when the dog was napping during Janet’s session, she told her therapist that the dog was a, “mean doggy,” and that the dog had always disliked her. Janet also described her step-father as “mean” for leaving the family to go to jail. The therapist and Janet processed the reaction that she had to the dog’s nap time and related it to the sense of abandonment she felt following her step-father’s incarceration. In a family session, Janet, Bonnie, and Lena worked together to practice each of the therapy dog’s tricks. The therapist processed this with the family, and Bonnie related the exercise to the ways that Janet and Lena could set boundaries and create emotional safety plans.

**Parent Interview.** In the parent interview, Bonnie shared that she had initially been skeptical about involving her children in therapy, but was very pleased with the progress that Janet made in therapy. Bonnie described Janet’s relationship with the therapy dog as very helpful, and explained that Janet might not have been as interested in going to therapy if the dog was not involved. Bonnie shared that Janet felt emotionally safe while the dog was present and that this helped Janet to open up in therapy. Per Bonnie’s report, Janet’s behavior improved significantly and she was doing better overall.

**FETCH.** Janet’s FETCH drawing (Figure 10) includes three figures, a child (identified as girl), a dog, and a cat. The figures are drawn in pencil, and appear to be floating as they are parallel with the sun. The figures occupy less than a quarter of the page. There are two hearts drawn in pencil directly underneath the figures. The drawing includes a yellow sun on the top left-hand corner of the page, and a green grounding line that represents grass.
Developmental Aspects of Drawing. The figures include hair, facial features, and shapes for bodies. However, the figures lack details on arms and legs. Overall, Janet’s drawings are rudimentary and lack a formal, schematic framework. Janet’s drawings are consistent with the pre-schematic stage of drawing, which occurs from ages four to seven years. The figures represent early approximations of children and animals, but have some features of the earlier scribbling stage (Malchiodi, 1998). Janet’s grounding line would be expected from a child in the schematic stage, which typically occurs between age seven to nine years. It is significant that the more sophisticated components of the drawing are in color, while the more rudimentary aspects are drawn in pencil.

Emotional Aspects of Drawing. The bright coloring of the sun and grass are in contrast to the pencil sketch of the figures and hearts. Visually, this conveys alternate emotional experiences. Use of brighter colors often align with positive emotional content, while the lack of colors might align with and absence of emotionality. The hearts are often associated with a history of sexual abuse (Trowbridge, 1995). However, Malchiodi (1998) cautions against taking
a literal approach to analyzing drawings based on pre-determined associations. Janet and Bonnie have not disclosed any history of sexual abuse, and one cannot assume this history solely on the basis of a drawing. Hearts are also an item that a six-year-old girl might commonly draw; it also might be an item that Janet feels capable of drawing. However, the inclusion of the large hearts (which are bigger than all three figures) does represent emotional content; whatever the hearts represent to Janet holds importance.

**FETCH Story.** In Janet’s FETCH story, the dog, cat, and girl went to the park. The dog and cat were play fighting in the park, and the girl joined into the play fighting. When the girl and both animals finished playing in the park, they went to the girl’s home, and had a meal together. Janet explained that the girl lived with both the dog and the cat, and that the girl lived with her grandmother. The girl, dog, and cat went to sleep and woke up together and went back to the park to play. In the second day at the park, the girls and her animals ran around, and played under a waterfall. At the end of the story, the girl and her animals smiled at one another.

**Salient Themes.** Overall, Janet’s FETCH drawing and accompanying story are consistent with her age and developmental level. Her decision to include a cat and the large hearts, however, showed an ability to think outside of the bounds of the original drawing prompt. These figures might be items Janet draws frequently and feels confident depicting. This is consistent with Janet’s initial response to the FETCH prompt, which was to say she “can’t [draw] dogs.” This again evokes the Eriksonian (1997) school-aged conflict of industry versus inferiority. Janet did not feel confident in her ability to draw a child and a dog, but did feel able to draw these figures. It might be that drawing the hearts and cat provided Janet with the confidence to draw the child and the dog.
Lena, Age 8.

Therapy Referral. Several weeks after Janet began therapy, Bonnie contacted the therapist about enrolling Lena in the program. Bonnie shared that Lena was not showing the same symptoms as Janet, but still expressed concern about Lena’s well-being in light of her exposure to violence and her father’s incarceration. Bonnie shared that Lena had had opportunities to visit her father in prison. While Bonnie acknowledged that maintaining a relationship with her father was positive for Lena’s well-being, she also expressed concern about how visiting prison might have negative emotional implications. Bonnie shared that Lena appeared to have some anger following the family’s shelter intake, and often expressed this anger verbally and through relational aggression towards her peers. While Lena has not been in trouble at school, her teacher shared concerns with Bonnie during a parent-teacher conference. Bonnie and Lena identified several treatment goals during the intake session, including processing past trauma and building coping skills to deal with any symptoms that arise.

Developmental History. The therapeutic services intake form, which included information about developmental history, was not available for this participant.

Trauma History. In her CCTI assessment, Lena identified several potentially traumatic events including her father’s arrest and subsequent incarceration, witnessing community violence, and her maternal grandfather’s sudden death. Like Janet, Lena did not disclose the domestic violence relationship between Bonnie and her stepfather during the CCTI, but did process this trauma during her subsequent play therapy sessions. Lena identified experiencing several symptoms that could be associated with post-traumatic stress. Symptoms included mood swings, difficulty maintaining behavioral control, and difficulty coping with change.

Treatment History. Lena also worked with the therapist trained in AAPT. She
participated in nine therapy sessions, and the therapy dog was present for four of those sessions. Like her sister, Lena also had conjoint and family sessions with Bonnie and Janet. In one family session, Lena and her family created a joint painting. Each family member took turns creating one or more brushstrokes and the ultimate result was a co-constructed art project. In this activity, Lena deferred to her younger sister when deciding which colors to paint with and where on the paper she would paint. Bonnie explained that Lena often responded to Janet in this way. In subsequent family sessions, Lena and Janet processed this dynamic in sand tray activities. For example, when the family was preparing to leave the shelter, the therapist directed each family member to occupy one third of the sand tray with their ideal picture of their new apartment. When Janet attempted to take over some of Lena’s space in the sand tray, Lena instructed Janet to stay in her own section of the tray. This demonstrated Lena’s capacity to advocate for herself, which was reflected in Lena’s behavior outside of the session. In this session, Bonnie shared that Lena was better able to set boundaries with her younger sister outside of therapy.

Lena enjoyed working with the therapy dog, and often made recreational visits to the therapist’s office to visit the dog. The therapist and Lena practiced several of the dog’s cues, and Lena helped the therapist in training the dog to roll a basketball with his nose (a trick that Janet also enjoyed cueing the dog to do). Lena also spoke directly to the dog during her sessions and shared with the dog that she missed her father. During the course of treatment, Steven’s (Lena’s father) girlfriend died suddenly. Lena came to visit the therapist’s office after learning about this individual’s death, and spoke directly to the dog and appeared to be comforted by the dog’s presence. It is notable that Janet did not seek the therapist out when this individual died; Bonnie attributed this to Janet’s limited contact with her stepfather’s girlfriend.

**Parent Interview.** In the parent research interview, Bonnie shared that Lena formed a
strong relationship with the therapy dog and often mentioned the dog after the family moved out of the shelter. Bonnie summarized Lena’s experience in treatment as very helpful, and shared that therapy empowered Lena to set appropriate limits with her sister. During the interview, which occurred several months after the family’s shelter stay, Bonnie expressed interest in continuing therapy for her daughters. Bonnie explained that Lena and Janet continued to fight and believed that therapy could assist her daughters in working through this; Bonnie hoped that she could find another therapist that worked with a therapy dog.

**FETCH.**

![FETCH Drawing](image)

*Figure 11. Lena Martin FETCH Drawing*

Lena’s completed her FETCH drawing (Figure 11) quickly and using only pencil. The drawing is comprised of two figures, one of a dog, and one of a child identified as a girl. The figures took up approximately one-sixth of the page, and Lena did not include a grounding line or other context. The girl figure includes hair and a small dress, and the face includes a smile. The girl’s arms and legs are minimally drawn and do not include hands or feet. The dog figure also has a smiling face, but does not include ears or detail in the body. The dog’s tail is curly and also is missing one leg.
After she finished the FETCH drawing, Lena turned the paper over and created a second drawing (Figure 12). This drawing included four colors, including a pencil. The picture fills three-quarters of the page, and includes a house, a tree, a flower, and a sun. The picture also includes two human figures. Each figure has hair, facial expressions, and clothing. Again, the arms and legs are drawn as straight lines and without hands or feet. There is a grounding line below the main drawing. There is a written title below the main drawing, “Her and Brother was Fright and Hits.” It is important to note that, as indicated in the genogram, Lena does not have a brother.

**Developmental Aspects of Drawing.** Lena’s two drawings represent different developmental stages of drawing. The original FETCH drawing is consistent with the pre-schematic stage; the figures are rudimentary and lack detail. The second drawing includes spatial depth, additional color, and a baseline; these are all features of the schematic drawing stage (Malchiodi, 1998). At age nine, Lena would be expected to be at the end of the schematic stage. The second drawing is developmentally appropriate, while the FETCH drawing is significantly below Lena’s developmental level. In the second drawing, Lena demonstrated that she is capable
of drawing at an age appropriate level.

**Emotional Aspects of Drawing.** The drawings have significantly different emotional connotations. The FETCH drawing includes smiling faces, but lacks color or any other positive emotional context. The second drawing is colorful, has a full composition, and has a generally positive emotional connotation. However, the title of the drawing which refers to fighting and violence is in contrast to the positive emotional context of the drawing.

**FETCH Story.** In Lena’s story, the dog had only three legs and a very wiggly tail. Lena explained that a wiggly tail often meant that dogs were happy. The dog and the child, identified as a girl, lived together in the same home. One day, the dog ran away when the girl was sleeping. The dog wanted to go outside and couldn’t wake the girl up. After the dog ran away, the girl tried to find the dog but was unsuccessful. At the end of her story, Lena shared that the girl never found the dog. Lena told a second story to accompany her second picture. She identified the two human figures as a woman and her little brother. In Lena’s story, the children lived alone without parents. One sunny day, the little brother became angry because there was no food in the fridge and the brother began fighting with and hitting the girl. At the end of the story, the girl bought lots of food for her brother and her brother apologized. Lena’s narrative might reflect the appeasement that her mother demonstrated in response to her fathers’ abusive behavior prior to leaving him.

**Salient Themes.** In therapy, Lena learned to set boundaries and enhance her coping skills. In creating both a FETCH drawing and a second drawing, she exemplified her ability to do both. Lena demonstrated that she is able to follow directions but also express herself in a way that feels appropriate to her. The conflicting emotional content and developmental contexts of Lena’s drawings mirror the experience that she had in therapy. Lena entered therapy with a somewhat
parentified role in her family. Through therapy, Lena was allowed to play and get in touch with age-appropriate interests. The therapy dog facilitated this process, and the therapy dog’s curly tail is visually depicted in the FETCH drawing. The rudimentary figures in her FETCH drawing might represent a disconnect between Lena’s chronological and developmental ages.

It is significant that Lena’s FETCH story ends with the dog being lost and not returning. The dog escapes because his needs are not being met, and the girl (the caretaker in the story) is unaware of the dog’s absence. Lena’s second drawing and the accompanying story include similar themes; the children are without an adult caretaker and violence only occurs when the children find themselves without food. In both stories, the characters fight for survival and are unsure of whether they can rely on other people to meet their needs. Lena’s family has experienced a series of losses and traumatic events; her drawings and stories might reflect some of the uncertainty that she feels as result.

**Case Vignette: Williams Family**

Julia Williams and her two children moved in the shelter after spending several years ‘house-hopping’ and staying with friends for months at a time. Prior to this, Julia lived with her boyfriend James Senior, who moved across the country following an amicable break-up. James Senior maintains occasional contact with their son, James (age 6), but does not provide financial support to the family. Julia’s father died when she was a young child, and Julia is no longer on speaking terms with her mother. Julia explained that she and her mother were unable to resolve a conflict borne out of a childhood trauma, but did not disclose further details about this. Julia has always struggled to find and maintain steady employment and the family lacked financial stability.
Julia has a second son, Elijah (age 1), with her current boyfriend, Maurice. Soon after Elijah’s birth, Julia was arrested for possession of marijuana and spent two months in jail. During Julia’s incarceration, James and Elijah lived with Maurice; the long-term plan was for the four of them to find an apartment together. After her release, Julia found that her criminal record was a barrier to housing and employment. She decided to enroll in a work-readiness program and sought shelter through the city’s emergency housing program in hopes of building the skills to be able to live independently. Maurice continued to be involved in Elijah and James’ lives, and visited the boys on a weekly basis during the shelter stay. Maurice’s home did not have enough room for both children, and Julia was not financially stable enough to rent her own apartment. She was unable to identify a friend or relative willing to house her, and entered the city’s shelter system after spending one night sleeping outside with the boys.

Figure 13. Williams Family Genogram
James, Age 6.

Therapy Referral. Julia initially approached the therapy services program for assistance with managing James’ behavior, which she described as ‘out of control.’ Julia shared that James had difficulty sitting still in school and had increased emotional outbursts since entering the shelter. Julia also shared that James became very upset when he spent time away from Julia, and sometimes vomited upon their separation. During the parent intake session, the therapist provided some psychoeducation about behavioral responses to loss and change, as well as information about expected developmental milestones. Julia and the therapist identified therapeutic goals for James, including developing coping skills for times of high emotionality and processing the loss and trauma he has experienced. In this session, Julia disclosed her own history of depression, and requested a referral for her own therapy. Concurrent to James’ therapy, Julia enrolled in a mental health case management program offered by the shelter.

Developmental History. In the intake session, Julia reported that her pregnancy with James had been healthy, and she received appropriate pre-natal care. Julia did not remember James’ birth weight, but recalled that he was healthy at birth and the pregnancy was full-term. Julia bottle-fed James, and he had no issues with feeding or colic during the first year of life. Per Julia’s report, James met developmental milestones at the following ages: he crawled as six months, walked at ten months, and said his first word (“not”) at approximately nine months. Julia reported that James completed toilet training at two years, and did not experience any issues with toileting until the family entered the shelter. Julia shared that James wet the bed once or twice each week at the shelter, and expressed relief when the therapist shared that many other children exhibited this symptom as a response to stress or transition.

Trauma History. In his CCTI, James reported several potentially traumatic experiences
including his mother’s arrest, for which he was present, and subsequent incarceration. He also reported his father’s absence, and the murder of his uncle when he was four. James reported several symptoms that could be indicative of post-traumatic stress. These symptoms include nightmares, bed-wetting, emotional outbursts, and hypervigilance. Julia also shared that James was sometimes unaware of his surroundings and lacked some insight with regards to safety. Julia expressed significant concern about this, and believed he would someday fall victim to a predator because of his trusting nature.

**Treatment History.** James participated in six play therapy sessions and the therapy dog was present for each of those sessions. Julia scheduled and subsequently cancelled several sessions, so James’ six sessions were spread out over three months. Julia was proactive in reaching out to the therapist when there was an imminent need, such as a complaint from his teacher but struggled to maintain consistent therapy attendance. James enjoyed telling stories using the sand tray, and used superheroes to communicate his own emotional experiences. For example, James often played with a Bat Man figurine and staged scenarios in which Bat Man became angry and had difficulty finding ways to calm down. In a joint session, James and his therapist collaborated with Julia to brainstorm and test out anger management techniques. Following this session, Julia and James both began deep breathing at night before bed and then started using breathing techniques when they were angry or stressed.

James worked with the therapist trained in AAPT and expressed significant interest in spending time with the therapy dog. James referred to the dog as his friend, and would sit next to the dog and tell the dog about his day. The therapist introduced James to some of the therapy dog’s cues and tricks. While James expressed interest in observing the therapist cue the dog’s tricks, he was less enthusiastic about learning how to cue the tricks himself. When James learned
that the dog knew how to high five, he expressed excitement and stated that this made the
therapy dog ‘just like a person.’ Furthermore, James would visit the therapist’s office periodically
to see whether the dog was present. James expressed disappointment when the dog was not there,
but resisted leaving the office when the dog was there. Typically, James would spend most of
these informal visits petting the dog and then telling the dog about his day.

**Parent Interview.** In the parent research interview, Julia shared that she hoped to enroll
James in therapy now that they were out of the shelter, but did not have time to do so. Julia
shared that over the course of therapy and since leaving the shelter, many of James’ immature
behaviors such as ‘baby talk’ or bedwetting had subsided. Julia expressed gratitude for James’
relationship with the therapy dog, as the family had a dog they needed to give away before
entering the shelter. Julia shared that she hoped to have a family dog in the future, and that the
therapy dog allowed James to have the benefits of a dog during a stressful time of the family’s
life.

**FETCH.** James used five crayon colors to compose his FETCH drawing. The drawing
took up half of the page, and included three figures: a dog, a child (identified as a boy), and a
third figure (identified as an octopus). The picture includes a sun, and a blue line that James
identified as a bridge. However, there are no other context cues or a grounding line. Next to the
dog figure, there is a small brown circle that James identified as feces.

**Developmental Aspects of Drawing.** At age six, James would be expected to be in the
pre-schematic stage of drawing (Malchiodi, 1998). James’ emerging representation of human
figures, even at a rudimentary level, is reflective of this stage of drawing. His attention to detail
in the dog figure (right), which he described as being a side view, is notable. He identified the
small circle in the right circle as an ear, and shared that because the dog had a flat face, the nose
was not visible. While the dog figure appears rudimentary, James’ description of the figure suggests that some conceptual planning preceded the process of drawing it. This would be more consistent with a more advanced stage of drawing.

![James Williams FETCH Drawing](image)

*Figure 14. James Williams FETCH Drawing*

**Emotional Aspects of Drawing.** The main figures in James’ drawing lack facial details including mouths and eyebrows. It is therefore difficult to decipher whether James intended to have his figures expressing emotional states. The overall appearance of James’ drawing could suggest positive emotionality; he used several bright colors to create his figures, and the sun is in the top center of the page. Furthermore, the child figure is in the center of the page and is in close proximity to the dog.

**FETCH Story.** In James’ FETCH story, the boy and the dog are going for a walk through the city. It was a very sunny day and the dog and boy were both sweating. On the walk, the dog defecated and the boy cleaned up after the dog. The dog and boy crossed over a bridge and viewed an octopus in the water. The octopus advanced on the boy and dog, and the boy and dog jumped up and scared the octopus away. James shared that the dog and boy both felt scared when the octopus was threatening them, but that they were happy for the rest of the story.
Salient Themes. James’ FETCH drawing and narrative is unique among the group for two reasons. First, James included an antagonist (the octopus) who threatens the experience that the dog and child are having. Second, James included the action of the dog defecating and drew the dog’s feces at part of the FETCH drawing. Each distinguishing characteristic has significance within the context of James’ treatment history and life circumstances.

Throughout James’ life, he has moved several times, lost family members to death and cut-offs, and experienced separation from each of his parents. This lack of consistency was reflected in James’ sporadic attendance in therapy. Despite the difficulty James had in attending therapy on a regular basis, he formed a relationship with the therapy dog. Both James and Julia described the time that James spent with the dog as a meaningful and positive experience. James characterized the relationship between the dog and child as happy and positive in the FETCH story. The octopus/antagonist could represent a threat to the stability that the child-dog relationship represents.

James’ inclusion of feces reflects his own struggle with bodily functions. When Julia initially met with James’ therapist, she shared that James would vomit when separated from Julia at daycare. James also experienced enuresis since coming to the shelter. On the surface, the dog’s act of defecation might reflect James’ own experiences of losing control of bodily functions. However, in the FETCH story, the boy picked up the dog’s feces. This action could represent mastery over uncertainty, and control over one’s destiny. This is consistent with Erikson’s (1997) school-aged conflict of industry versus inferiority.

Case Vignette: Lee Family

Naomi Lee and her four children moved into the shelter following Naomi’s separation from her husband Timothy, the father of two of her children. Naomi and Timothy’s relationship
grew tense, and Timothy’s verbal aggression towards Naomi prompted her to leave. Naomi struggled to find work, and was unable to maintain a stable housing arrangement. 

She considered returning to live with Timothy, but worried that the verbal aggression might escalate to physical aggression and place her children at risk. Naomi and her children spent weeks at a time staying with friends, and spent two months in a shelter one year prior to entering the shelter in which the study was conducted. When Naomi and her four children entered the shelter, the children started a new school. Two of Naomi’s children, Timmy and Ariel, received therapy while in the shelter. All four of the Lee children formed a close bond with the therapy dog and frequently visited the therapy office (often with Naomi) to spend time with the dog.

**Timmy, Age 10.**

*Therapy Referral.* Timmy was the first of the Lee children to enroll in the therapy
program. He began acting out behaviorally in his new school, and had been physically bullied by his classmates. Naomi expressed concern that Timmy might be lonely and struggling socially. In the initial intake session, Naomi shared that Timmy’s main behavioral issues were restlessness, disturbing classmates in school, stealing, and disobedience. Naomi explained that she had observed Timmy shoplifting small items on several occasions, and wasn’t sure how to handle it. Naomi shared that Timmy had an ADHD diagnosis and had taken Ritalin previously to manage hyperactive symptoms. Naomi identified several goals for therapy, including Timmy increasing his self-esteem, and increasing communication skills about his emotional experience. She also shared that she wanted to learn some new strategies for disciplining Timmy.

*Developmental History.* Naomi shared that her pregnancy with Timmy had been healthy, and he was born at thirty-five weeks and weighed approximately six pounds, zero ounces. Naomi breast-fed Timmy for two years, and Timmy struggled to wean. Naomi shared that she experienced postpartum depression following Timmy’s birth. According to Naomi’s report, Timmy did not crawl but walked at around ten months. He knew ten words at one year, and spoke in sentences at nineteen months. Timmy completed toilet training at eighteen months, and Naomi shared that Timmy was the easiest of her four children to toilet train. At age three, Timmy began having frequent tantrums both at home and at work. Naomi characterized these tantrums as intense, and were one of the reasons why Naomi had Timmy evaluated by an early intervention specialist. This ultimately led to Timmy’s ADHD diagnosis. Naomi shared that when he was eight, Timmy set fire to the school bathroom. He received therapy through a local juvenile justice program and, until the family’s intake in the shelter, Timmy had been behaviorally stable.

*Trauma History.* In his CCTI, Timmy reported several traumatic experiences. This
included being physically hurt by his classmates, going to the emergency department after accidentally drinking bleach, witnessing physical fighting in his neighborhood, witnessing verbal alterations between his parents, and being robbed outside of the local convenience store. He also considered his fire setting incident, and the response to this event as traumatic. Timmy reported several symptoms associated with post-traumatic stress including difficulty regulating his emotions, hyper-vigilance, difficulty concentrating in school, and poor self-esteem. Later in therapy, Timmy disclosed that his father was verbally and physically abusive towards. There was a child protective services investigation following this report and Timmy’s father was not awarded custody.

_Treatment History._ Timmy participated in ten play therapy sessions, and worked with the therapist trained in AAPT. Overall, Timmy showed a strong preference for working in the sand tray. He often selected superhero or green army men figurines and created stories about the figures battling against each other and adapting to changes in their lives after the battles ended. In a joint session, Timmy and Naomi selected all of the bug figurines and created a humorous story about the bugs taking over the world. Timmy chose to call the story “bug world.” It is important to note that during this time period, Timothy filed for custody of Timmy and Timmy was privy to some of the court proceedings between Naomi and Timothy. Timmy played a parentified role in his family, and often helped Naomi care for Tonia. Throughout therapy, Timmy often wore a crown from the play room’s dress-up area during his sessions.

When working with the therapy dog, Timmy expressed an interest in learning about the dog’s cues and body language. Timmy learned the components of clicker training and assisted the therapist in teaching the therapy dog how to jump over a small tower of blocks. The therapist and Timmy played an emotions identification game with the therapy dog in which the dog
hunted for treats in a basket full of toys with emotions stuffed toys. When the dog took a toy out of the basket, Timmy would generate a potential reason for the dog to have that particular emotions (example: “The dog is surprised because I turned into a dog”). As Timmy continued playing this game, he communicated his own emotions through the lens of the dog (example: the dog is confused because his parents are getting divorced”).

**Parent Interview.** In the parent research interview, Naomi shared that since leaving the shelter, Timmy’s behavior in school had deteriorated and he had been suspended for getting into a fight with a classmate. Per Naomi’s report, Timmy has asked to see a therapist again. Naomi shared that in therapy, Timmy developed some strategies for dealing with difficult emotions. Naomi shared that Timmy enjoyed attending therapy, likely because he had someone outside of the family to talk to. Naomi explained that dogs had always been important to the family, and that all of her children enjoyed spending time with the therapy dog. Timmy showed particular interest in the dog, and urged Naomi to adopt a dog after the family left shelter. Timmy took on the responsibility of feeding and walking the dog, and called the dog his “daughter” when he spoke about her. This role largely replaced the caregiving responsibilities he had for his baby sister Tonia.

**FETCH.** Timmy’s FETCH drawing (Figure 16), is drawn with black and blue crayons. There are three clouds, drawn carefully and across the top of the page. The clouds are the drawn in blue, and the rest of the picture is drawn in black. The drawing contains two figures— a dog, and a child (identified as a boy). The boy is a stick figure, and lacks detail in the body. He has a smile on his face, and a crown on his head. The boy and dog are connected by a leash. The dog has a circular body and a round head, and appears to have a smile on his face. The dog has ears pointed upward and several large circles on the body. The dog has four stick legs and lacks a tail.
Developmental Aspects of Drawing. As a ten-year old, Timmy would be expected to be beyond the schematic stage of drawing, and on the brink of the dawning realism stage of drawing (Malchiodi, 1998). In this stage, children might begin to demonstrate depiction of spatial depth and have an increased focused on accurate color usage. In his interview, Timmy identified the dog’s legs as having spatial depth; the back legs appear shorter than the front legs. However, other aspects of the child and dog figure lack the sophistication of the dog’s legs, and are more consistent with the schematic or preschematic stage of drawing. The clouds, though rudimentary, were drawn slowly and carefully. Timmy demonstrated consistency in how they appear, both in their size and shape. These figures might be considered an established approach to drawing an element of nature, which is indicative of the dawning realism stage.

Emotional Aspects of Drawing. Timmy’s drawing includes some elements of both negative and positive emotionality. The clouds, which Timmy spent more time sketching than the other figures, are colored blue and occupy most of the top line of the page. While clouds could signal impending weather of any type, these clouds appear light and fluffy. The overall tone of the clouds is hopeful. Both the dog and child are drawn in black crayon, which might suggest a
negative or neutral tone. However, both figures have smiling expressions on their faces and both figures are connected by a leash. The dog and child’s physical proximity might be interpreted as emotional closeness.

**FETCH Story.** In his FETCH story, Timmy began by explaining that the dog had escaped from the pound. The boy, who was playing hopscotch by himself in the park, saw the dog and approached the dog. Timmy explained that the park was far away from the pound and that when the dog escaped, the pound manager chased after the dog with a large hunting net. The dog jumped onto a train and stayed on until the end of the train line, which was near the park. The dog was on the train for the entire day and saw the boy when he jumped off the train. When the boy approached the dog, the dog was scared and made a whimpering sound (which Timmy imitated while telling the story). The boy’s mother went to the park to pick up the boy and the boy asked to keep the dog. The mother agreed to let the boy keep the dog and the dog became less scared as he got to know the boy better. Timmy shared that the dog was a brown bulldog and that the family in the picture also adopted a female dog and the dogs had puppies together and lived a long and happy life.

**Salient Themes.** In the drawing, the boy figure has a crown on his head, similar to the play crown that Timmy often wore when he was in therapy. Timmy wore the crown when discussing or playing through difficult emotional themes, and it can be assumed that the crown afforded Timmy some confidence or bravery. In his drawing and the accompanying story, Timmy’s dog figure was scared and the boy protected the dog. The crown on the boy figure’s head might represent the confidence that the boy figure summoned in order to provide protection for the dog. In therapy, Timmy gained a sense of mastery through learning about dog behavior and dog training. This experience helped him to continue his growth after therapy ended, and
through his relationship with the family dog.

The physical proximity of the dog and the child figures, along with the leash that connects them, could be interpreted as representing an attachment bond. This could reflect the bond that Timmy shared with the therapy dog and with his family dog. In this interpretation, the lengthy train ride takes on an additional meaning. The dog in Timmy’s story was fleeing an angry pound employee and took a long train ride in order to find safety, security, and attachment. The title Timmy chose, “The Journey,” might reflect the process of finding safety and purpose through therapy.

Ariel, Age 11.

Therapy Referral. Timmy’s sister Ariel requested that she begin therapy after meeting the therapy dog during a recreational visit. Ariel expressed a strong interest in learning more about the dog, and asked that Naomi enroll her in the program. In the initial intake appointment, Naomi described Ariel as quiet and reserved, and expressed hope that therapy might allow Ariel an opportunity to better express herself. Naomi also shared that Ariel was diagnosed with epilepsy and began having seizures at thirteen months of age. The most recent seizure occurred at the shelter, and Ariel expressed extreme embarrassment that her peers witnessed her seizure. Naomi did not report any externalizing behavioral symptoms but expressed concern about Ariel’s sleeplessness since entering the shelter, and her poor self-esteem. Naomi and the therapist identified several goals for therapy, including processing the changes the family has experienced, and developing coping skills for dealing with difficult emotions.

Developmental History. Naomi reported that her pregnancy with Ariel had been healthy and that Ariel was born at full term. Ariel weighed seven pounds, thirteen ounces at birth and, other than a bout with jaundice, was very healthy. Naomi breastfed Ariel, and reported that Ariel
struggled to wean. Ultimately, Ariel weaned at about twenty-four months, which is significantly later than average. It is possible that Naomi herself struggled to wean her children. Apart from seizures, Ariel was relatively healthy and met developmental milestones at the following ages. She crawled at five months, walked at eleven months and spoke in full sentences at eighteen months. Ariel completed toilet training at two years, and Naomi did not report any difficulties toilet training Ariel. Naomi shared that Ariel experienced tantrums around age three, and that the tantrums were less intense than her other children’s.

**Trauma History.** In one of her sessions, Ariel’s therapist administered the UCLA PTSD Index (Rodriguez, Steinberg, & Pynoos, 1999). In this interview, Ariel reported several potential traumatic events including the death of her grandmother, witnessing violence in her neighborhood, her parents’ separation, and having seizures. It is important to note that Timmy note report his grandmother’s death as a potentially traumatic experience. Ariel identified her seizures as the most upsetting of these. She shared that was often upset by the knowledge that others might see her with a stiff body, foaming at the mouth, and with her eyes rolled backward. Ariel reported several symptoms consistent with post-traumatic stress including emotional numbing, hypervigilance, difficulty sleeping, and exaggerated startle response.

**Treatment History.** Ariel had therapy with the therapist trained in AAPT and had five play therapy sessions. She had some difficulty engaging in non-directive play therapy, but appeared to enjoy playing board games that enhanced her emotions identification skills and discussing the social dynamics at her school. The therapist recommended that Ariel begin keeping a journal to record some of her experiences, and Ariel expressed interest in this idea. In subsequent sessions, Ariel brought her journal to the therapist’s office and would speak directly to the therapy dog as she recounted some of the event she wrote about in her journal. When the
protective services investigation began, following Timmy’s report of abuse, Ariel wrote about some of the difficult emotions she had in her journal.

After her fifth session, Ariel told Naomi that she wanted to stop therapy. The therapist had a brief meeting with Naomi and Ariel to discuss termination. Ariel explained that she enjoyed spending time with the therapy dog, and like writing in a journal, but was not as interested in the other components of therapy. The therapist invited Ariel to continue therapy at any time, and shared that many children in the shelter made recreational visits to the therapy dog. Ariel visited the dog several times during the remainder of her shelter stay. In these visits, she expressed interest in brushing and playing with the dog, but was less interested in the dog’s cues and tricks.

**Parent Interview.** In the research interview, Naomi shared that while Ariel had not spoken with a therapist since the family left the shelter, Ariel did sometimes mention the therapy dog. Ariel’s still occasionally wrote or drew in her journal, and Naomi note that it was helpful for her to have an outlet with which to express her emotions. Because the Lee family adopted a dog after leaving the shelter, Ariel continued to have opportunity to interact with a dog, although she was not as involved in the dog’s care as Timmy.

**FETCH.** Ariel’s FETCH drawing included a dog figure and a child figure, each drawn in monochrome; the child is all black, and the dog is all brown. Both figures lack facial features, and there is minimal detail on the child’s body which resembles a rudimentary stick. The dog has a round body with four legs resembling sticks. The child and dog are close in proximity but, without facial expressions, it is unclear whether they are seeking proximity. Unlike other FETCH drawings, there are no leashes or other tangible connectors. The figures occupy about one quarter of the page, and there are no grounding lines or other contextual cues.
Developmental Aspects of Drawing. Ariel’s drawing is consistent with a much earlier stage of drawing than one would expect from an eleven-year-old girl. The lack of grounding lines, or details in the figures are consistent with pre-schematic drawings (Malchiodi, 1998). Yet, the drawing is difficult to assess developmentally due to the quickness of Ariel’s process; she drew this picture in under thirty seconds. It could therefore be considered a drawing that was created as a psychoanalytic defense (Malchiodi, 1998). This might suggest that Ariel did not express her full developmental drawing skills in favor of concealing some deep truth through her artwork.

Emotional Aspects of Drawing. The drawing does not include any overt emotional content, such as facial expressions or scenic context. In fact, Ariel appeared to make a conscious effort not to include emotional content. Both figures are sparsely drawn, and could be interpreted as having a dark or negative emotional tone. Another interpretation would be consistent with the drawing as an expression of psychoanalytic defense (Malchiodi, 1998). This might elicit themes of emotional avoidance or numbness, which the lack of detail in Ariel’s drawing is consistent with.

FETCH Story. In the narrative accompanying her FETCH drawing, Ariel told a brief
story about the child (whose gender was not identified), going to a veterinarian’s office where the dog was living. The child adopted the dog, because dogs who needed new homes were living at this veterinary office. The dog was so happy to be adopted, and then the dog and child went to the park to play. Ariel did not provide additional details about this, even with some cueing. Ariel did end the story with a prediction that the child would grow up and continue to care for the dog, who would have puppies. The child (now grown), dog, and puppies would become a family. This parallels the ending of her brother Timmy’s narrative.

**Salient Themes.** The sparse FETCH drawing and limited details of the FETCH narrative resemble the difficulty Ariel had engaging in therapy. If the story and picture are indicative of psychoanalytic defense, Ariel’s difficulty engaging in therapy might provide further evidence of these defenses. After Ariel asked to terminate therapy, she shared that therapy was not what she had expected it to be. Ariel expressed interest in ‘being friends’ with her therapist, but shared that she was upset by the professional nature of the relationship. For example, Ariel expressed disappointment when the therapist greeted Ariel briefly in the hall outside of the therapy office, rather than engaging in lengthy and casual conversation.

Through leaving therapy, but continuing to engage with the therapy dog in non-clinical settings, Ariel set a boundary with the therapist and communicated how she was willing to engage in the therapy process. It is notable that the dog character has a more fleshed out storyline than the child. The dog is the story’s protagonist, and the child is a character in the dog’s narrative. This might suggest that Ariel’s relationship with the dog was memorable and significant, and might have helped Ariel to develop stronger engagement in therapy if the family had stayed in the shelter longer. Another interpretation of Ariel’s narrative and drawing might be as an expression of her expected role as the quiet, well-behaved sibling. As the proverbial
“squeaky wheel” that does not receive attention, she may feel that her needs are overshadowed by her brother. The sparse drawing and minimal storyline for the child figure could reflect the role she plays in her family.

**Case Vignette: Moore Family**

Jeana Moore and her two children moved into the shelter following Jeana’s separation from her boyfriend Nathan, who was also the father of her youngest child, Nate. Prior to living with Nathan, Jeana lived with her boyfriend Henry, who is the father of her daughter, Brianna (age 6). Henry grew violent towards Jeana and, after Brianna witnessed a particularly violent incident, Jeana left out of fear for Brianna’s safety. Jeana briefly lived with her mother, and then began dating Nathan. While Nathan maintained contact with Nate following their break-up, he no longer provided support to Jeana. Jeana searched for housing, but was unable to maintain steady employment and therefore struggled to make rent payments. Jeana’s mother, Eliza, was unable to allow Jeana and her children to stay with her. The Moore family entered the city shelter system seeking a fresh start, and Jeana hoped to make use of the support services provided in order to find employment and develop skills necessary to maintain a stable housing arrangement.

Brianna entered the shelter at a time when there were several other children her age in residence. She began Kindergarten at the local elementary school and would walk to school with other families from the shelter. She reported that she loved having friends with whom she attended school. Initially, Brianna thrived in school socially and academically; she frequently participated in activities offered at the shelter. Nate benefitted from the nurturing presence of shelter staff and the other resident mothers, and began meeting developmental milestones. Several weeks into the shelter stay, Brianna began to struggle and Jeana sought therapy for her. Brianna agreed to participate in the study and Jeana completed a parent interview.
Therapy Referral. Jeana sought therapy when Brianna began displaying excessive worry and increased tantrums. Brianna’s teacher reported that Brianna would become very worried about completing tasks during the school day, and would become fixated on drawing pictures perfectly, for example. Brianna met with a school counselor, who taught her some deep breathing techniques, which Brianna implemented at her teacher’s suggestion. While this brief intervention was successful, Jeana expressed concern that Brianna might be reacting to the transition into the shelter, and enrolled in therapy to help support her daughter. Jeana and Brianna identified several treatment goals including decreasing tantrums and increasing coping ability. Because Brianna rarely threw tantrums earlier in her life, Jeana was unsure of how to help Brianna manage emotional outbursts.

Developmental History. In the initial intake session, Jeana shared that she experienced
gestational diabetes and preeclampsia when pregnant with Brianna. There were no complications at birth, and Brianna weighed six pounds, four ounces. Jeana began breastfeeding Brianna, but soon discovered that Brianna was lactose intolerant and transitioned to soy formula. Per Jeana's report, Brianna met developmental milestones at the following ages. She crawled at seven months, and began walking at ten months. Jeana shared that Brianna toilet trained at eighteen months. This is earlier than would be developmentally expected; it is unclear from the treatment record whether Jeana misremembered the exact age that Brianna toilet trained, or if Brianna toilet trained early. Initially, Jeana denied any early life trauma history; when the therapist built rapport with the family, she shared that Henry, Brianna’s father, became physically abusive towards her when Brianna was an infant. This continued until Brianna was three, and the family left Henry’s home.

**Trauma History.** In an early session, Brianna was administered the CCTI. She identified several potentially traumatic events, including her grandmother’s history of incarceration, witnessing community violence, and the death of her cousin. Brianna shared that a violent incident between her mother and father was the most upsetting of these events, and shared that police came to her home as result of this incident and her mom sustained some injuries that required a hospital visit. Brianna reported experiencing several symptoms potentially associated with post-traumatic stress including hypervigilance, nightmares, difficulty regulating her affect.

**Treatment History.** Brianna participated in nine play therapy sessions with the therapist trained in AAPT, six of which had been with the therapy dog. Because she had not spent significant time with dogs before, Brianna expressed initial hesitation about working with the therapy dog. Jeana was present the first time Brianna met the dog, and the therapist taught Brianna how to pet the dog and how to recognize whether the dog was showing stress or
enjoyment based on norms of canine body language. Brianna grew more comfortable spending time with the dog, and ultimately asked Jeana to leave the session so she could play with the dog. In subsequent sessions, Brianna would integrate the dog into her non-directive play even if the dog was not actively participating. She would cook pretend meals for the dog in the play kitchen and, if the dog was sleeping, Brianna would narrate that the dog was in the dog hospital and pretend that she was a nurse or doctor caring for the dog.

After three sessions, Brianna stated that she was more comfortable with the dog and wanted to feed him some treats. With some guidance from the therapist, Brianna fed the dog from a treat out of her hand, and laughed as she shared that the dog’s tongue tickled her finger. As therapy continued, Brianna and the therapist played games with the dog that increased Brianna’s contact with the dog in increasing frequency. Using the dog’s approach to finding treats as a model, Brianna and the therapist discussed ways to manage frustration and find different approaches to solving problems. In joint sessions with Jeana, Brianna taught her mother how the dog communicates his needs and, in parallel, considered alternative ways to communicate anger and disappointment to her mother. One technique the therapist introduced to achieve this goal was to act out alternative responses using puppets or dramatic play. When Brianna and Jeana left the shelter, Brianna had completed nine sessions but expressed interest in continuing therapy. The therapist provided referrals to clinical resources in the neighborhood the family planned to move to.

*Parent Interview.* In the research interview, which was conducted seven months after the family left the shelter, Jeana shared that Brianna’s excessive worry dissipated when the family entered independent housing. Jeana hypothesized that this could have been due to the change in environment, or due to the therapy sessions. Jeana shared that Brianna was enrolled in group
therapy in her current school, and that Brianna was continuing to learn new coping skills in the
group. Per Jeana’s report, Brianna enjoyed the therapy group, but missed the therapy dog. Jeana
expressed gratitude for the opportunity Brianna had to form a relationship with the dog. She
stated that if the family’s had the financial resources, she would have liked to have a dog or cat;
the therapy dog allowed Brianna to spend time with and learn about an animal.

FETCH.

Figure 19. Brianna Moore FETCH Drawing

In her FETCH drawing (Figure 19), Brianna used all eight crayons provided, and drew
her figures along the perimeter of the page. The child, who she identified as a girl, began as a
stick figure, and Brianna added clothing and shoes to the figure. There are no legs or hands. The
girl has a smiling face and long hair with circles on the end of each strand; Brianna identified the
circles as beads in the girls’ hair. There is green sketching along the bottom of the page, which
Brianna identified as a grass. There is a small, yellow sun in the top left-hand corner. The dog
figure is on the opposite side of the page from the child figure, and has long ears, a collar, and
four stick legs; the dog also has a long tail that points upwards at the end. Brianna drew flowers
and butterflies throughout the drawing, and there appears to be a butterfly on the dog’s back. At
the top of the page, Brianna wrote the word “pets” and underlined it.
**Developmental Aspects of Drawing.** At age six, Brianna would be expected to draw figures in the preschematic stage (Malchiodi, 1998). Although some of the figures have rudimentary components, including the child’s missing limbs and the dog’s “smiley face” style head, there is evidence of a pre-determined schema for drawing flowers, butterflies, and long hair. This, combined with the existence of a grounding line and an overall composition of the picture, are most consistent with the schematic stage of drawing. Developmentally, Brianna’s depiction of the girl figure’s hair as disproportionately large to the body is consistent with pre-adolescent or adolescent girls (Burns, 1982).

**Emotional Aspects of Drawing.** Both figures in Brianna’s FETCH drawing have smiling faces, and the bright colors and composition suggest an overall positive emotional tone. It is important to note that the dog figure is almost a full-page length away from the girl figure, and appears to be facing away from the girl. This could suggest avoidance or disconnection, or it could speak to an emotional closeness that does not require physical closeness. The dog is wearing a collar, which suggests that the dog is cared for by someone, possibly the girl.

**FETCH Story.** In Brianna’s FETCH narrative, the girl and the dog were named Katy and Max, respectively. At the moment the drawing depicts, Katy and Max were playing tag in the park and laughing while the butterflies flew around them. They both enjoyed looking at the flowers and were very happy. Brianna explained that Katy adopted Max from an animal shelter (“the place that dogs go when they have no owner”) and that they spent all of their time together. Brianna described their favorite activities as eating together, drawing pictures of each other, and going for walks. When she mentioned that Katy and Max liked to walk together, she drew a collar on Max’s neck. Brianna titled the picture “Pets,” and wrote this word along the top of the page.
**Salient Themes.** The positioning of the girl and dog figures, despite the physical separation, suggest a secure attachment relationship (Bowlby, 1977). Brianna included a collar, a symbolic indicator of belonging, but did not include a leash, which would physically connect the figures. It could be that this was an oversight, but she was intentional in other aspects of the drawing. The collar might signify that, due to the closeness of Max and Katy’s relationship, the restriction of the leash is unnecessary; Max will return to Katy when called, and will not run from her when chased. The game Katy and Max played, “tag,” involves one figure, called ‘it’ Chasing another until the figure ‘tagged’ the play partner. At this point, the roles switch, the tagged individual becomes ‘it,’ and the game begins again. This could be likened to the cycle of shadowing and darting away that are hallmarks of the rapprochement crisis (Mahler, Bergman, and Pine, 1975). When the love object responds to rapprochement with firm, loving boundaries, the child is able to move towards Bowlby’s (1977) characterization of a secure attachment bond.

Brianna’s picture and accompanying narrative has hallmarks of a ‘finished’ product. The picture occupies most of the page, is composed of full color, and the figures include clothing and accessories. In the narrative, each figure has a name and there is a title and an origin story that provides context for the present moment. This is unique among the drawings included in the study. This reflects the experience that Brianna had in therapy. Like other participating children, she experienced trauma, but she and Jeana experienced a high level of engagement and involvement in therapy. Jeana called the therapist to cancel appointments, while other families did not call before missing appointments. The family requested a referral to additional therapeutic services, and made telephone contact with the new therapist prior to the family’s departure from the shelter. Jeana’s ability to set clear boundaries with therapy arrangements is reflective of the clear, firm boundaries that Jeana is able to set. The completeness of Brianna’s
drawing and story communicate the firm, loving boundaries her mother has set.

**Theoretical Analysis**

The content of children’s FETCH drawings and narratives evoked concepts associated with attachment experiences. Some content directly reflected the attachment disruptions and challenges that are common to children of chronically homeless families including a child’s compromised sense of safety, the caregiver’s focus on survival needs, and the overall expectation of instability or unpredictability (Meadows-Oliver, 2005; Smolen, 2014; Roschelle, 2017). Other content spoke to healthy, age-appropriate attachment experiences including self-efficacy and safe risk-taking (Shilkret & Shilkret, 2011; Milyavskaya & Lydon, 2013). While these concepts might not reflect the lived experiences of participating children, they are consistent with Jalongo’s (2009) application of attachment theory to the human-canine bond. This chapter explores the ways that children reflected both lived and wished-for attachment experiences in their drawings and narratives. To contextualize the representations of attachment experiences, the primary investigator integrated and triangulated information from a child’s clinical chart, parent interview, as well as the FETCH drawing and story.

**Personalization of Drawings**

Across the projective drawing literature, children’s inclusion of their own characteristics in projective drawings, or reference to specific or discrete characteristics in their narratives, suggest personalization of the drawing (Burns & Kaufman, 1987; Malchiodi, 1998; Kaiser 2009). Themes that emerge from personalized projective drawings can be interpreted as representing the experiences of the children who drew the picture. In the present study, participants personalized their FETCH drawings in numerous ways. All eleven participants identified the “child” in their FETCH drawing as having the same gender with which they
identify. Most children referred to the child figure by the same-gendered pronoun during the narrative; seven of the children drew figures with features typically associated with their gender, such as long hair for girls. Two participants drew their human figure using brown crayon, which might reflect their African American racial identity. Several participants also drew child figures that included distinctive aspects of their own appearance. Felice drew a child figure that included a striped skirt and puffy sleeves, reflecting the clothing she wore on the day she completed her FETCH drawing. Similarly, Brianna wore braids with small plastic beads in them. The child figure in her drawing had small circles drawn throughout each hair strand, which she identified as beads. Inclusion of a child’s own characteristics in a drawing suggests that the child has communicated some facet of their personal experience (Malchiodi, 1998).

Some children’s drawings depicted features that were not personal characteristics, but bore resemblance to symbols or themes that they frequently explored in their play therapy sessions. Timmy drew his child figure wearing a crown, reflective of the costume crown he often wore during his play therapy sessions when he explored difficult or traumatic content. The crown could be interpreted as the power or bravery that he sought to assist him in facing the abuse and trauma that precluded his family’s homelessness. Lena, who drew a second picture, often chose to work in the art area during play sessions. The second, more detailed drawing could be interpreted as an attempt to express her emotional experience in a medium that is comfortable and safe. James drew an octopus, which he identified as an aggressor towards the child and dog figures. This is symbolically similar to the scenes he enacted in the sand tray in which a Bat Man figure faced off against a series of villains in battle. Through symbolism in play therapy, children express facets of their real-life and emotional experiences, including fantasies and wished-for outcomes (O’Connor, 2010; VanFleet, Sywulak, & Sniscak, 2010).
Children’s personalization of drawings, or their inclusion of themes frequently explored during play therapy, were a critical part of analysis. The characteristics suggest that children’s lived and wished-for experiences of attachment are represented in their drawings and narratives. The primary investigator reviewed clinical charts and parent interviews to distinguish between the lived and wished-for attachment experiences.

**Personalization of the Dog Drawings.** Because the FETCH projective drawing task was developed for the current study, literature suggesting norms for analysis does not yet exist. However, several visual and verbal indicators bore resemblance to the therapy dogs involved in the AAPT treatment participants received. Both *Dot* and *Lena* drew dogs with curly tails; one of the therapy dogs was a pug mix who also had a curly tail. *Timmy* described his dog drawing as a “bulldog […] with a short nose.” *Timmy* may be referencing the same dog, who had a short nose and sometimes was called a bulldog by children. *Brianna* drew a dog with long ears; the other therapy dog was a beagle with notably long ears. Projective drawing literature suggests that personalized drawings of children tap into the child’s own experiences; this can be extrapolated to consider that drawings of animals with identifiable features may communicate children’s experiences with particular animals (Burns & Kaufman, 1987; Malchiodi, 1998; Kaiser 2009). Overall, the prevalence of personalized drawings of both children and dogs suggests that, in this sample, children’s FETCH drawings spoke to the experiences, both lived and wished-for, that children have had with animals, including the therapy dogs involved in their treatment.

**Symbolism of the Dog**

The attachment literature on the human-animal bond provided further context for analyzing concepts found within the children’s drawings and narratives. In a comprehensive review of the child-dog relationship, Jalongo (2009) compared aspects of this relationship to the
attachment bonds developed between infants and their primary caregivers including proximity seeking, the expectation of protection, resisting separation, and the existence of a secure base from which to explore. These concepts are represented in children’s drawings and narratives (Table 8).

<table>
<thead>
<tr>
<th>Attachment Concept</th>
<th>Manifestations in Child’s Drawing or Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proximity Seeking</td>
<td>➢ Dog and child sharing physical space or making physical contact (e.g. petting; dog sitting in child’s lap)</td>
</tr>
<tr>
<td></td>
<td>➢ Dog and child walking towards one another</td>
</tr>
<tr>
<td>Expectation (or Lack of) Protection</td>
<td>➢ Dog in front of child</td>
</tr>
<tr>
<td></td>
<td>➢ Dog assuming a protective stance</td>
</tr>
<tr>
<td></td>
<td>➢ Dog and child under a tent or other enclosure</td>
</tr>
<tr>
<td></td>
<td>➢ Child and dog in a vulnerable position</td>
</tr>
<tr>
<td></td>
<td>➢ Dog harming the child; child harming the dog</td>
</tr>
<tr>
<td>Separation or Resisting Separation</td>
<td>➢ Dog and child saying goodbye</td>
</tr>
<tr>
<td></td>
<td>➢ Child with thought bubble including the dog</td>
</tr>
<tr>
<td></td>
<td>➢ Walls/ barriers separating the child and dog</td>
</tr>
<tr>
<td></td>
<td>➢ Restraints on the child or dog</td>
</tr>
<tr>
<td>Secure Base (or Lack Thereof)</td>
<td>➢ Child looking towards dog</td>
</tr>
<tr>
<td></td>
<td>➢ Family of dogs or dog part of the child’s family</td>
</tr>
</tbody>
</table>

*Table 8. Manifestations of Jalongo’s (2009) Attachment Concepts*

In this comparison, the child often symbolically took on the role of the caregiver in this dyad. Dogs rely on humanity for their basic survival needs including food and shelter, just as infants rely on primary caregivers to meet their survival needs (Range & Viryani, 2015). Children also reap some of the benefits of attachment from the perspective of the cared-for individual. Dogs provide warmth, comfort and companionship to their humans, just as human caregivers do for their infants (Serpell, 2002). Jalongo’s (2009) parallel between parent-child and child-dog relationship is in some ways an imperfect comparison because the child’s role may shift between the caregiver and the cared-for individual. This is reflected in the children’s drawings and narratives. For example, in Timmy’s story, the dog figure was autonomous as he escaped from the pound, but required the care of the child figure upon arrival at his new destination. In turn, the dog figure met emotional needs of the boy, who was lonely prior to
meeting the dog. *Timmy’s* narrative provided a rich example of the shifting nature of the roles played by dogs and children in the attachment framework.

**Lived Attachment Experiences**

Review of children’s clinical charts and the transcripts of parent research interviews revealed that the children experienced repeated early-life disruptions in attachment relationships. Some of these disruptions were due to physical separations such as parental incarceration, early childhood hospitalization due to illness, or parental abandonment. Some attachment disruptions resulted from a caregiver’s emotional absence despite physical presence, most notably, when a parent was experiencing intimate partner violence. Children’s experiences were consistent with the literature on trauma and child homelessness. Homeless children reported rates of potentially traumatic experiences at close to one-hundred percent, with the most common trauma types involving physical or emotional separation from a primary caregiver (Herbers et al., 2015). Through FETCH drawings and narratives, children communicated these experiences of separation, and the emotional impact that these experiences have had.

**Disruption in early attachment experiences.** Eight of the children’s narratives featured a storyline that involved the dog and child becoming separated and later reuniting. Some children’s narratives focused primarily on the events of the dog becoming lost. In *Dot’s* story, the dog ran away and became lost in a bush. The child became scared when the dog ran away and worried that she would not be reunited with the dog. *Gregory* chronicled the story of a dog coming loose from his leash and running away from the child. The dog was almost hit by a car. In both *Dot* and *Gregory’s* stories, the child cried and expressed strong negative emotions in response to the dog’s departure. Some children referred to the dog becoming lost prior to the events of the narrative; these stories focused on the child finding the dog. In *Charlie’s* story, the
child found the dog in the park and brought the dog home to live with his family. *Timmy’s* story featured the dog escaping from the pound and thwarting a dog catcher’s attempts to stop him; the dog traveled a long distance on a train to find the child. *Ariel’s* child figure went to a veterinarian’s office to meet a dog that was up for adoption. In each narrative, the child figure took on a rescuer role, saving the dog from a potentially dangerous situation.

The themes of “lost and found” are evocative of the attachment-related concept of *rapprochement*, the developmental crisis in which children aged approximately eighteen to thirty-six months struggle to understand their caregivers as a separate entity from themselves, while also accepting that their caregiver plays a vital role in their survival (Mahler, Bergman, & Pine, 1975). Successful navigation of the *rapprochement* crisis requires a consistent, patient presence from the caregiver or primary love object. Contemporary scholarship of family homelessness suggests that, while homeless mothers go to extraordinary lengths to secure housing, food, and basic medical care for their children, they often struggle to regulate their own emotions and, in turn, may lack the emotional framework to respond to their children with patience and consistency (David, Gelberg, & Suchman, 2012). These challenges were compounded by the high rates of maternal depression in homeless families, and the high incidence of childhood trauma among homeless mothers (Roschelle, 2017; Bassuk & Beardslee, 2014).

While the children’s narratives represented different points of time in the story arch of the dog becoming lost and subsequently found, the focus is on the child’s role or potential role in rescuing the dog from danger. In *Lena’s* narrative, the dog ran because he did not believe that the child would meet his survival need of needing to use the bathroom. The dog never returned, and was permanently separated from the child due to the lack of expectation of protection (Jalongo,
The children’s stories introduce an external, real-life crisis in which the child-dog dyad parallels the parent-child relationship. The dog figures struggled with whether they could trust the child figures to care for them. As a group, these narratives might be interpreted as a symbolic representation of the internal conflict of the *rapprochement* crisis and a way to develop mastery via the role reversal.

**Practical concerns about survival needs.** It has been established in the literature that the daily life stressors of parenting while homeless could impede on mothers’ capacity to meet their child’s need for emotional regulation, often due to mothers’ own struggles to meet family survival needs (Meadows-Oliver, 2005). The challenges are compounded by families’ lack of social support. Homelessness is the result not of just a lack of housing, but of the lack of a support network that might have served as a safety net (Bassuk, DeCandia, Beach, & Berman, 2014). Without this network to rely on, homeless mothers may depend on their children to assist in tasks that promote the overall safety and well-being of the family unit. For example, homeless children may be responsible for the care of their younger siblings (Henry, Cortes, Shivji, & Buck, 2014). In this role, children were likely to become privy to financial and other survival needs associated with family’s risk of homelessness; their awareness of family survival needs is beyond what would be expected for their developmental level.

Children communicated their knowledge of their family concerns for survival needs in their drawings and narratives, through storylines that featured the child and dog seeking basic necessities. Children also made specific reference to the housing status of the dog depicted in the FETCH drawing, and chronicled the journey that dogs made to seek safety. In *Nan’s* drawing, the text below both the dog and cat figures suggested that these figures were depicted digging in dirt. In her narrative, *Nan* explained that the cat figure was proficient at digging, and was able to “dig
a hole in the ground [in which] to live” and also used the hole to hide its food from other animals. The dog in Nan’s drawing also dug a hole, but struggled to survive without the cat’s prowess for digging and foraging. The dog was unwanted by the people around him, and needed to find a place to live. Nan did not provide a resolution to the dog’s story, but described the dog and cat as “living close to each other” but never meeting. This could be interpreted as representing competition for scarce resources, an experience that homeless families have faced in seeking one of the city’s limited shelter beds (Henry, Cortes, Shivji, & Buck, 2014).

In Lena’s narrative, the dog figure lived with the child figure in a family home. One night, while the dog and child slept, the dog wanted to go outside to urinate. The dog did not trust that the child would allow the dog to go outside, so the dog left the house and never returned to the girl. Upon discovering the dog’s absence, the girl was devastated that “her favorite dog and her only dog” was gone. When Lena drew a second picture of a girl and her brother, she explained that the siblings fought violently over what they believed to be the last scrap of food. There was no mention of a parental figure in this story, or of another food source. As in Nan’s narrative, the second story suggested competition over scarce or limited resources. Furthermore, both of Lena’s stories suggested that the vulnerable party in the attachment dyad was unable to rely on their caregiver to meet basic survival needs. Homeless children who take on adult and parentified roles within their family may lack the expectation of protection from an attachment figure (Jalongo, 2009). Therefore, they may have developed autonomous roles in having survival needs met. According to their treatment records, children that participated in the study were referred to therapy for a wide range of behavioral challenges including fighting, and shoplifting small items. These behaviors could be interpreted within the context of promoting their own safety and survival.
Compromised sense of safety. Challenges faced by homeless families limit the ability of children to develop a felt sense of emotional safety (Smolen, 2014). Homeless children’s safety is compromised by threats to physical survival including violence, illness, inadequate nutrition and housing, as well as perceived threats to safety including lack of physical affection, and emotional absence of a caregiver (Herbers et al., 2014; David, Gelberg & Suchman, 2012). Simply put, homeless children are frequently placed in situations that compromise their safety; as result, they may not develop a general expectation of physical and emotional safety. This is consistent with the symptoms of post-traumatic stress, including hypervigilance and nightmares, reported during treatment and evoked in the children’s drawings and narratives, (Rodriguez, Steinberg, & Pynoos, 1999; King, Solomon, & Ford, 2016). Children represented their lack of a felt sense of safety through the content of their FETCH drawings and narratives.

In the projective drawing literature, a grounding line across the bottom of page provides geographical context to pictures, and is a developmentally expected feature in the drawings of children over the age of five years (Lowenfeld & Brittain, 1982). Lack of a grounding line, which occurred in eight of the eleven drawings, may indicate that a child is behind in their artistic development, or is demonstrating signs of trauma and disrupted attachment experiences (Malchiodi, 1998). Similarly, in six of the eleven drawings, children drew figures without any scenery or other geographic context. These figures were drawn in the center of the page, and have the appearance of floating. Some figures were drawn in close proximity, but none of the figures were drawn as touching one another. Drawn figures’ lack of physical contact has been shown to correlate with experiences of trauma and measurements of insecure attachment style (Backos & Samuelson, 2017; Singh and Roussouw, 2015). While the drawings did not depict imminent danger, they also did not depict resources that would foster a sense of safety. The
desolate appearance of some children’s drawings reflected that children lacked an expectation of protection and predictability.

Children also expressed a compromised sense of safety through the content of their narratives. *James* described octopus that, when his child and dog figures went on an ordinary walk, tried to jump out of the water to “get” the child and dog. Presumably, this language referred to the octopus intending to harm the figures. In *Gregory’s* narrative, the dog figure “ran off” from the child figure and narrowly missed being hit by a car. *Ariel’s* dog figure was rescued from a veterinary clinic where he did not have any stimulation or contact with other dogs; *Ariel* described the dog as “bored to death.” Each of these narratives represented a different kind of loss or threat which was ultimately thwarted by the child figure. *James’* figures were nearly attacked by an aggressor, *Gregory’s* dog figure was almost killed by a vehicle, and *Ariel’s* dog figure was at risk of become increasingly isolated and withdrawn. These experiences represented credible threats to the lives, safety, and well-being of the characters in children’s narratives, and reflect that high rate of traumatic exposure in this population (Herbers et al., 2014). However, the children rescue or save the dog figures, preventing the dog figure from experiencing trauma.

**Wished-For Attachment Experiences**

In contrast to the frequent depictions of loss and trauma in the drawings were indicators of healthy attachment. As discussed previously, children included themes in their drawings and narratives that also appeared in their play therapy. Through the medium of play therapy, children express themes from real and wished-for experiences (O’Connor, 2010; VanFleet, Sywulak, & Sniscak, 2010). This extends to AAPT, in which the relationship between a child and a therapy animal, “can develop, strengthen, and sustain healthy attachments for children and adults who have suffered in those areas” (VanFleet & Faa-Thompson, 2017, p. 250). The elements of
drawings and narratives that suggested a healthy attachment between the child and dog figures might represent a wished-for attachment experience developed through children’s positive and nurturing experiences with the therapy dog.

**Formation of stable and predictable relationships.** Nearly all of the children’s drawings and narratives included the dog figure as part of the child figure’s family unit. Some children stated that the dog had joined the family prior to the events of the narrative. At the beginning of the story, *Dot* introduced the dog and girl as living in the same house and, “eat[ing] together, play[ing] together [and] go[ing] to sleep together.” In *Gregory’s* story, the dog and child, “live in the same house” from the beginning of the story. Several children chronicled the dog joining the child’s family. *Charlie’s* child figure, “gave [the dog] some food and took [the dog] home.” In *Ariel’s* story, the child “went to the vet and picked up the dog” because the dog had no home. Finally, some children’s narratives featured the dog procreating and further expanding the family that the child and dog share. *Timmy’s* narrative ended with the family adopting, “another dog […] a girl dog, […] and they had babies.”

The common theme was not just that the dog figures joined the child figure’s family, but that the dog figure found a safe place to live and thrived within this environment. In each of these narratives, the dog figure escaped a setting that minimally met their physical survival needs and failed to meet their emotional needs. The dog figures’ points of origin included an animal shelter staffed by a villainous manager, a veterinary office in which the dog was not allowed to go outside, and a park in which the dog lacked food and shelter. These settings could be compared to homeless children’s environments, in which traumatic exposure and disrupted early attachment experiences contribute to a compromised sense of safety (Smolen, 2014). Children created their own, imagined families within the context of these FETCH drawings and narratives.
These families were nurturing and relationships between family members were playful and loving.

**Leashes and collars.** Children represented the wished-for attachment experiences through visible symbols of the child-dog relationship: leashes and collars. Four of the eleven children’s drawings included leashes. *Felice* did not include a leash, but noted that the dog, “had no leash” and identified this as an indicator that the dog lacked a caregiver and therefore required the child figure to take responsibility for the dog’s wellbeing. The research on canine symbolism on projective drawing research is limited, but the concepts of attachment can be applied to the notion of the leash. A leash connects an animal to a human and, as *Felice* noted in her narrative, may identify the ownership of the dog. As a representation of a healthy attachment experiences, a dog and owner would walk side-by-side and the owner might view the leash as a way to protect the dog from danger such as an oncoming car or an aggressive dog on the street (Jalongo, 2009). In order to train a dog to walk beside the owner with a loose leash, one must spend time positively reinforcing this behavior through relationship-based training (Pryor, 2002). Therefore, a dog and owner that communicate while using a leash have developed a relationship based on trust, and may share a bond similar to a positive attachment relationship between a child and their caregiver.

The visual appearance of the leashes provided additional insight into the nature of the wished-for attachment relationships children depicted. In the dog training literature, a relationship has been established between fearful behavior in dogs and aversive leash handling. In some cases, dogs have developed leash reactivity, an anxious aggressive response to the stimulus of a leash, due to being handled in this manner (American Veterinary Society of Animal Behavior, 2008). A dog being pulled on a leash, which would appear taught, might react to a
caregiver out of fear and in order to avoid danger. In a drawing, a taught leash would likely be represented by a straight line between the child and dog figures.

For some clients of AAPT, psychoeducation about responsible leash handling might become part of their work with the therapy dog. Because therapy was implemented in a residential setting, the therapist sometimes walked with clients and the therapy dog around the building’s courtyard. For these clients, depiction of loose leash might reflect knowledge gained. Timmy and Gregory, who each expressed a strong interest in learning about the therapy dog’s body language, depicted leashes that were connected to the dog and, but were not held taught by the child figure. The connotation is that the dog is not being pulled with the leash, and is willingly walking with the child. This is particularly significant for Timmy who, before starting therapy, had only contact with dogs who were trained through aversive methods. It is reasonable to assume that his prior association with a leash was of a dog being pulled or yanked. The inclusion of a loose leash might suggest a secure attachment relationship between the child and dog, or that Timmy has developed new knowledge about ways to handle a leash while maintaining a trusting relationship (Shilkret & Shilkret, 2011; Pryor, 2002).

Brianna depicted a dog not wearing a leash, but wearing a collar, a symbol of ownership and identity. The dog in her picture was facing away from the child figure but was turned to look back towards the child. Collars are often used to hold to identification tags with the owner’s phone numbers, evidence of rabies vaccination, or microchipping. Sometimes collars are connected to leashes; yanking or pulling a leash attached to a collar in and aversive manner can restrict the dog’s airway (Pryor, 2002). Harnesses, which wrap around the dog’s shoulders and chest, are generally recommended to attach to leashes (American Veterinary Society of Animal Behavior, 2008). This allows for the dog to have increased freedom of movement without
restricting the airway and breathing. The use of a harness necessitates training to guide the dog to walk next to its human; a playful and relationship-based approach to training can engage the dog in this process and facilitate attachment between the dog and its owner (Pryor, 2002). Similar to a loose leash, a dog that is only collared but not leaving the child’s side could signal trust and partnership, indicative of a secure attachment style. In Brianna’s picture, the collar and tags identify the dog figure as belonging to the child. The dog is not physically connected to the child by a leash but, according to the drawings and narratives, remains close to the child. The dog exhibit’s Jalongo’s (2009) attachment concept of the expectation of protection; the child meets that expectation and, in response, the dog remains physically close to the child.

**Self-efficacy.** Children communicated wished-for attachment experiences not only through the actual nature of relationships between child and dog figures, but also through personal characteristics that are developed through healthy attachment experiences. These include the development of self-efficacy, or the belief in one’s own abilities. A healthy attachment relationship with a caregiver enables a child to develop the self-efficacy necessary to face new challenges (Shilkret & Shilkret, 2011). The foundational literature on AAPT has identified self-efficacy as a goal of the treatment model. VanFleet and Faa-Thompson (2017) wrote that self-efficacy is, “enhanced by the interaction with animals, during which clients can see with their own eyes that their behavior brings about change” (p. 241). Development of self-efficacy is a crucial step towards seeking mastery over difficult life experiences or developmental tasks. Children communicated the self-efficacy associated with their wished-for attachment experiences through their drawing processes.

As previously discussed, children’s drawings were more rudimentary than what would be expected for their developmental level (Lowenfeld & Brittain, 1982). Aware of their deficit, five
of the eleven children responded to the original FETCH prompt with some version of the phrase: “I don’t know how to draw.” To compensate for their perceived deficit, children included additional figures that demonstrated their skill level and boosted their confidence prior to drawing dog and child figures, which challenged their sense of self-efficacy. Many children added figures beyond the required child and dog. Nan and Janet both included cats. James added an octopus. Brianna filled most of the page with several butterflies, one of which was located on the dog figure. Janet articulated that while she had not felt confident drawing a dog, she “[knew] how to draw a cat” and selected to draw this figure before beginning the dog and child figures in order to demonstrate their artistic ability and build the confidence necessary to approach the unfamiliar task of drawing a dog. Brianna drew the butterfly figures with ease, as though she drew these often. The ability to repeatedly complete a task suggests sense of self-efficacy (Shilkret & Shilkret, 2011).

Several children also included text within their FETCH drawings. Gregory drew two word bubbles each with the phrase, “Hey,” coming from each of the figure’s mouths. Similarly, Nan had word bubbles coming from each of the three figures she drew; the cat is saying, “maw,” the dog is saying, “roof,” and the girl is saying, “I am happy.” Some children wrote the title of their drawing or story across the page of the FETCH drawing. Charlie wrote, “the lost dog and the boy” as he stated that this was the title of his narrative. Likewise, when the primary investigator asked Brianna if she wanted to title her narrative, Brianna responded by writing the word “pets” on the page and pointing to it, as though she were signaling that the word was her response to the investigator’s question. Finally, some children also wrote their first names on the FETCH drawing (which was later redacted). If children felt uncertain about their ability to complete the prompted drawing task, or about the research setting, demonstrating a skill they
have confidence in might facilitate the feelings of support and self-efficacy necessary to enable children to take risk. Some children may have already felt that level of support. James, for example, struggles with writing in school but wrote his name on the FETCH drawing. James sought the primary investigator’s approval during the task, bidding for her attention and acknowledgment at his writing.

Risk-taking. One component of self-efficacy that stems from a healthy attachment relationship is a child’s ability to take safe, calculated risks (Shilkret & Shilkret, 2011). When children feel that survival needs are met and their emotional needs are attended to, they are able to take safe, developmentally-appropriate risks. For homeless children, the ability to take these risks represents a wished-for attachment experience. High rates of maternal depression and trauma, and the parentified roles that children assume preclude children from seeking validation through age-appropriate risk taking (Bassuk & Beardslee, 2014). Without the security of a positive attachment relationship, children may participate in risk-taking activities that are not age-appropriate or are harmful. Among homeless children, common risk-taking behaviors include drug use, para-suicidal behavior, and aggression towards their peers (Zlotnick, Tam, & Zerger, 2012). Children’s clinical charts revealed that participants engaged in harmful risk-taking behaviors including arson, physical violence, and truancy.

Children depicted safe, developmentally appropriate risk taking through the events of their narratives; child and dog figures learned new skills together, or one figure developed new skills on their own. Nan’s dog and cat figures were primarily identified by their ability to dig; the cat used its digging skills to find food and create a home. Timmy’s dog character rode a train for the first time, and found safety through the use of this newfound ability. James’ dog and child figures worked together to scare away an aggressor, the octopus, the first time they encountered
such a threat. In each scenario, characters attempted new skills in order to achieve or maintain safety within their environment. Furthermore, these characters developed new skills with the help of their companion in the child-dog dyad. Children took risks to express a wished-for attachment experience: not only did they develop age-appropriate new skills, they also found safety through their risk-taking actions.

**Parent Interviews**

Because parent interviews were conducted at least six months after families left the shelter and completed therapy involvement, the primary investigator was able to inquire about whether children’s wished-for attachment experiences came to fruition. Timmy’s mother reported that he was performing well in school and was relating positively to his peers and family members. Notably, Timmy’s family had been able to adopt a dog, who Timmy took responsibility for walking and feeding. In fact, Timmy’s mother reported that he often called the dog his daughter. Prior to beginning therapy, Timmy struggled significantly with both the academic and social components of school, and had been involved with the juvenile justice system at a very young age. His mother credited Timmy’s relationship with the therapy dog and, subsequently, the new family dog with his behavioral improvement.

Prior to therapy, Timmy’s lived attachment experiences resembled those highlighted in this section. He experienced several early-life physical and emotional attachment disruptions, which evoked concerns for basic survival needs and challenged his sense of safety. His relationship with the therapy dog, and the dog his family adopted after leaving the shelter helped him to develop a more stable and predictable style of relating to his peers. Timmy demonstrated the strength of his attachment experiences through feelings of self-efficacy and safe risk-taking in his care for and training in the new family dog. Timmy’s journey in therapy exemplifies the
impact that AAPT can have on the lives of children with challenging attachment and trauma histories.

**Conclusions and Implications**

The results of the study have implications across the substantive research areas of play therapy, animal assisted therapy, projective drawing research, and service provision to homeless families. More specifically, these findings provide insight into the utility of the FETCH as a clinical measurement tool, and the range of benefits to be derived from implementing AAPT in shelter settings. The findings have the potential to inform future research and continued development of best practices, and speak to the need for expanded training opportunities for social workers in these substantive areas.

**Projective Drawings**

Drawings are reflections of children’s worldviews; systematic study of children’s drawings can provide unique insight into the lives of marginalized and otherwise vulnerable children (Malchiodi, 1998; Harmon-Walker & Kaiser, 2009; Backos & Samuelson, 2017). In the present study, children communicated lived and wished-for attachment experiences through their drawings. These drawings represent a window into the inner worlds and experiences of homeless children. In the literature, child homelessness has been correlated with deficiencies in overall academic achievement, including reading and writing abilities below grade level (Perlman & Fantuzzo, 2010). Drawings therefore provide a developmentally appropriate medium through which to explore lived experiences of children living in shelters. Projective drawings can be utilized as a tool for further research on this population. The robust thematic content elicited from the FETCH drawing prompt suggest that this task might have potential for evaluating children’s experiences with dogs.
**FETCH as a Clinical Measurement Tool.** The common themes that emerged from analysis of FETCH drawings and narratives suggest that the projective drawing prompt taps into concepts related to children’s relationships with animals, and facets of early-life attachment experiences that these relationships elicit. Further study is required to elucidate specific correlates between aspects of children’s FETCH drawings and lived experiences. Validation studies conducted on Kaiser’s (1996) Birds Nest Drawing task provide a model for further study. Checklists of common features of the Birds Nest Drawing were developed and, when research teams administered the Birds Nest Drawing, the presence or absence of these features were found to correlate with standardized measures of attachment security. To ensure reliability of these studies, multiple raters completed the checklists of common features (Harmon-Walker & Kaiser, 2009; Kaiser & Deaser, 2009). These studies resulted in the establishment of a checklist for scoring Birds Nest Drawing drawings, and a body of literature supporting the association between aspects of children’s drawings and styles of attachment.

The primary investigator intends to continue researching the potential uses of the FETCH. Because the current study has a small sample size appropriate for qualitative analysis, future research would require larger samples and an expansion of the sampling frame. Preliminary research might focus on the development of checklist of visual aspects of FETCH drawings that warrant further exploration. Judging from the content of the present study, these elements might include the presence of leashes and collars, relative placement of dog and child figures, and inclusion of figures in addition to the dog and child. Depending on the population of interest, the checklist might include common milestones of artistic development. A checklist with well-established features would inform the next phase of validation research. Results of the present study indicate that the drawings evoke themes of attachment. Therefore, initial validation
studies might correlate aspects of children’s FETCH drawings with particular attachment styles or experiences, as measured by questionnaires or other measurement tools. Other potential correlates that could be explored in a validation study include experiences of particular trauma types, and attitudes and behaviors towards animals.

With empirical validation, the tool could be adapted for use as measurement of clinical progress in AAPT and other forms of canine-assisted interventions. Clinicians might administer the FETCH as part of an intake procedure and, with findings from further research on the tool, might use the content of the child’s initial FETCH drawing to inform treatment planning. Subsequent administration of the FETCH drawing could be analyzed to understand what, if any, changes might have occurred over the course of therapy with regards to concepts represented by FETCH drawings including attachment, trauma, and child-dog relationships. Outside of measuring clinical progress, FETCH drawings might be used to understand children’s attitudes about and relationships with dogs. This could include screening children for safe participation in canine-assisted therapy, which might inform clinicians on how best to help a child prepare for interactions with a therapy dog.

**AAPT in Emergency Housing Programs**

Despite the barriers identified in the literature that limit homeless families’ enrollment in mental health treatment, participating mothers and children positively described their experiences with the therapy dog. Mothers described the therapy dog as a welcome presence in the shelter, and children spoke about the therapy dog as a close friend. Moreover, several of the mothers reported that the therapy dog was the reason that they chose to sign their children up for therapy; mothers overcame negative associations with mental health treatment in order to provide their child with the experience of spending time with a dog. Mothers discussed
behavioral outcomes of therapy in follow-up interviews, and tended to credit the child’s relationship with the therapy dog with any decrease in problem behaviors or increase in desired behaviors. Mothers’ willingness to engage their families in therapy and their reports of the positive impact of therapy speak to the potential of canine-assisted therapy in engaging a population that tends to underutilize behavioral health treatment.

**Specific Clinical Benefits.** Results of the current study suggest that AAPT may be beneficial for children experiencing homelessness. Children in chronically homeless families are likely to have endured early-life traumatic experiences involving separation from a primary caregiver (Herbers et al., 2014). In their projective drawings, children communicated attachment experiences through the lens of the relationship between their child and dog figures. This may speak to the potential for this model to enhance attachment relationships, or at least to allow children to envision the possibility of positive attachment experiences. Furthermore, findings that speak to the development of self-efficacy through AAPT are also relevant to children facing homelessness. Child homelessness is correlated with challenges in academic and social contexts; as result, children may lack feelings of confidence and competence (Brumley et al., 2010). Children might learn new skills through working with a therapy dog, reinforcing the development of feelings of competency. The overall benefits of the AAPT modality are well matched with the needs of homeless children in therapy.

**Implications for Training and Education**

The present study provides support for the implementation of AAPT in homeless shelters, and the use of the FETCH projective drawing task as a tool for measuring clinical progress. Overall, the study suggests that further research is needed on the impact of play therapy and canine-assisted therapy on homeless children, as well as potential utility of projective drawings
in assessment. However, the experiential and expressive modalities explored are rarely accessible by families experiencing homelessness. Findings of the present study might inform assessment; for example, knowledge of the importance of pets in their clients’ lives might inspire professionals to ask about animals in the process of inquiring about family structure. Furthermore, the study could inform training of professionals working with this population, and helping them to re-conceptualize the kinds of services they to which they refer to homeless families.
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APPENDIX A: Participant Consent Form

Title of the Research Study: Animal Assisted Play Therapy™ for Children Living in Emergency Housing: A Projective Drawing Study
Principal Investigator: Katharine Wenocur, School of Social Policy and Practice
University of Pennsylvania, therapydogresearch@gmail.com

I am inviting you and your child to take part in a research study. Your participation is voluntary which means you can choose whether or not to participate. If you decide to participate or not to participate there will be no loss of benefits to which you are otherwise entitled.

This is not a form of treatment or therapy. It is not supposed to detect a disease or to find something wrong.

Before you make a decision you will need to know the purpose of the study, the possible risks and benefits for you and your child, and what you do if you decide to participate. I will talk with you about the study and give you this consent document to read. You do not have to make a decision now; you can take the consent document home and share it with anyone who helps you make decisions.

If you are confused about this form or about the research study, do not sign this form. Please ask the researcher to explain anything you do not understand, including any language contained in this form. If you and your child decide to participate, please sign this form and a copy will be given to you. Keep this form, in it you will find contact information and answers to questions about the study. You may ask to have this form read to you.

What is the purpose of the study?

This study is part of a dissertation project. The purpose of the study is to learn more about children’s experiences with therapy dogs in a form of treatment called, “Animal Assisted Play Therapy™.”

Why was I asked to participate in the study?

You are being asked to join this study because, during your stay at Jane Addams Place, your child received therapy or had supervised visits with the therapy dog (“Winston”) on at least three occasions.

How long will I be in the study?

The study will take place over a period of 2 years, however your participation will only require one meeting with the research team. We expect that you and your child’s participation will take less than 30 minutes.
Where will the study take place?

All aspects of the study will occur onsite at Jane Addams Place. With your written consent, one member of the research team will meet with your child one-on-one. A second member of the research team will meet with you in a separate room. You cannot be present in your child's meeting, but your child is able to leave the meeting at any time if s/he does not want to continue to participate in the study.

What will I be asked to do?

You will answer some questions about your child’s development, experiences at home before coming to the shelter, and his or her experience in therapy. Your child will be asked to draw a picture and will be asked several questions about the picture. Your child’s meeting will be audio recorded.

Consent for your child’s participation in this project means that the research team has your permission to look at records from your child’s therapy including, but not limited to, standardized measures and questionnaires completed when you arrived at Jane Addams Place.

What are the risks?

Although the risks of the study are minimal, your child might become upset or uncomfortable during the interviews. In this case the child will be given the option of stopping their participation and will be reunited with you.

How will I benefit from the study?

There is no benefit to you. However, your participation could help us understand how therapy dogs and Animal Assisted Play Therapy™ are helpful to families staying in emergency or transitional housing. The research may provide support for other shelters to bring therapy dogs onsite.

What other choices do I have?

You may choose not be in the study.

What happens if I do not choose to join the research study?

You may choose to join the study or you may choose not to join the study. Your participation is voluntary.

There is no penalty to you or your child if you choose not to join the research study. You will lose no benefits or advantages that are now coming to you, or would come to you in the future as a result of your participation in programs at Jane Addams House. Your case manager or other shelter staff will support your decision.
If you are currently receiving services and you choose not to volunteer in the research study, your services will continue.

**When is the study over? Can I leave the study before it ends?**

The study is expected to end after all participants have completed their one visit. The study may be stopped without your consent for the following reasons:

- The researchers feel it is best for your safety and/or health. In this situation, you will be informed of the reasons for stopping the study.
- You have not followed the study instructions.
- The researchers, Jane Addams Place, or the Office of Regulatory Affairs at the University of Pennsylvania can stop the study anytime.

**What information about me may be collected, used or shared with others?**

The researchers will retain information about your child’s attendance and participation in therapy, the results of symptom measures, and therapy notes taken by the therapist. You and your child’s names, contact information and date of birth will be redacted from the clinical record.

**Why is my information being used?**

Your information is used by the research team to contact you during the study. Your information and results of tests and procedures are used to evaluate the contents of you and your child’s interview, and your child’s drawing.

**Who may use and share information about me?**

The following individuals may use or share your information for this research study:

- Allison Werner-Lin, professor
- Katharine Wenocur, doctoral student
- Master’s level students involved in data collection

**Who, outside of the School of Social Policy and Practice, might receive my information?**

The researchers have applied for a grant from the Evelyn Ortner Center on Family Violence. If this grant is received, the Center will receive a summary of data collected for the study. Once your personal health information is disclosed to others outside the School of Social Policy and Practice, it may no longer be covered by federal privacy protection regulations.

The Principal Investigator or study staff will inform you if there are any additions to the list above during your active participation in the study. Any additions will be subject to University of Pennsylvania procedures developed to protect your privacy.

**How long may the School of Social Policy and Practice use or disclose my personal health information?**

Your authorization for use of your personal health information for this specific study does not expire. Your information may be held in a research database. However, the School of Social Policy and Practice may not re-use or re-disclose information collected in this study for a purpose other than this study unless:
• You have given written authorization
• The University of Pennsylvania’s Institutional Review Board grants permission
• As permitted by law

**Can I change my mind about giving permission for use of my information?**
Yes. You may withdraw or take away your permission to use and disclose your health information at any time. You do this by sending written notice to the investigator for the study. If you withdraw your permission, you will not be able to stay in this study.

**What if I decide not to give permission to use and give out my health information?**
Then you will not be able to be in this research study.

You will be given a copy of this Research Subject HIPAA Authorization describing your confidentiality and privacy rights for this study.

By signing this document you are permitting the School of Social Policy and Practice to use and disclose personal health information collected about you for research purposes as described above. You and your child have the right to drop out of the research study at anytime during your participation. There is no penalty or loss of benefits to which you are otherwise entitled if you decide to do so. Withdrawal will not interfere with your future care.

If you no longer wish to be in the research study, please contact Katharine Wenocur at therapydogresearch@gmail.com and request that your information be removed from the study.

**How will confidentiality be maintained and my privacy be protected?**
We will do our best to make sure that the personal information collected during the course of this research study will be kept private. However, we cannot guarantee total privacy. Your personal information may be given out if required by law.

If information from this study is used for teaching purposes by being published or presented at scientific meetings, your name and other personal or identifying information will not be used. Audio-recordings will be sent to an external transcription service. All audio recordings will be erased once data are compiled and analyzed.

**Will I have to pay for anything?**
You are not required to pay anything to participate in the study. If you are a former resident returning to Jane Addams for the study, you and your child will be given SEPTA tokens to cover travel expenses.

**Will I be paid for being in this study?**
At the completion of you and your child’s meetings with the researchers, your child will be allowed to keep the box of crayons used for the study and a small pad of paper as tokens of appreciation. You will receive $15 compensation for your time.
Who can I call with questions, complaints or if I’m concerned about my rights as a research participant?

If you have questions, concerns, or complaints regarding your participation in this research study or if you have any questions about your rights as a research participant, please speak with the Principal Investigator listed on page one of this form, Katharine Wenocur. If a member of the research team cannot be reached or you want to talk to someone other than those working on the study, you may contact the Office of Regulatory Affairs at the University of Pennsylvania by calling (215) 898-2614.

When you sign this document, you are agreeing to take part in this research study and allowing your child to participate. If you have any questions or there is something you do not understand, please ask. You will receive a copy of this consent document.

Signature of Subject  __________________________________________________________

Print Name of Subject  __________________________________________________________

Date  __________________________________________________________
APPENDIX B: Participant Assent Form

ASSENT TO PARTICIPATE IN RESEARCH

Attachment Implications of Animal Assisted Therapy

- My name is Katharine Wenocur.

- We are asking you to take part in a research project so I can learn more about what it is like for children to spend time with a therapy dog.

- If you agree to be in this study, I will ask you to draw a picture and talk to me about it. I will use a recorder to tape the conversation so that I can listen carefully to what we talk about. I won’t share your drawing or your name with anyone. I will keep the drawing and the recording when we’re done.

- There are no risks of this activity.

- There are no benefits of this activity, though you might enjoy the activity. The information we learn from this project might help other children who want to learn more about spending time with dogs.

- Please talk this over with your parent or guardian before you decide whether you want to be a part of the project. We will also ask your parent or guardian for permission for you to take part in this study. But even if your parent or guardian says “yes” you can still decide not to be in this study, and that’s fine.

- If you don’t want to be in this study, you do not have to participate. Remember, being in this study is up to you and no one will be upset if you don’t want to join. You can even if you change your mind later if you want to stop.

- You can ask me any questions that you have about this project. If you have a question later that you didn’t think of now, you can e-mail me at therapydogresearch@gmail.com or ask me the next time you see me.

- Signing your name below means that you agree to be in this study. I will give you and your parents a copy of this form after you sign it.

_________________________  __________________
Participant                    Date

_________________________  __________________
Investigator                  Date
APPENDIX C: Letter of Support (Lutheran Settlement House)

January 18, 2017

Ms. Katharine Wenocur
School of Social Policy and Practice
University of Pennsylvania
Philadelphia, PA 19104

Dear Ms. Wenocur,

On behalf of Jane Addams Place/ Lutheran Settlement House, I am pleased to confirm our agreement of understanding as well as to outline our responsibilities for collaboration on your dissertation research project, entitled, “Attachment implications of Animal Assisted Play Therapy™ for children living in emergency housing: a projective drawing study.” We look forward to learning more about the perspectives of the children and families we serve regarding their involvement with the therapy dog.

Specifically we agree to:

- Allow project researchers (provided that they have up-to-date child abuse clearances and criminal background checks) to review mental health records to determine child eligibility for research participation;
- Allow project researchers access to contact information of eligible participants for the purpose of recruitment.
- Provide office space for conducting interviews and administration of projective drawing measures and data collection with children.
- Allow for scheduling of regular meetings between researchers and shelter staff for project management and troubleshooting.
- Be responsible to bring any issues, problems or concerns to the research team.

Please know that we will do all that we can to ensure the success of this most worthwhile project. Please let us know if we can provide any additional information to you.

Sincerely,

Christine Stutman, LCSW, LSW
Executive Director
Jane Addams Place/ Lutheran Settlement House

www.lutheransettlement.org
APPENDIX D: Therapeutic Services Intake Form

Child’s Name: ____________________________________________________ Sex: (M)__(F)__

DOB: ____/______/_______ Age: _______ Nickname (if applicable): __________________________
Parent/guardian’s name: __________________________________________ DOB: ____/______/_______
If not the biological parent, specify relationship your child: _____________________________________
Residence (circle one): Jane Addams Place People’s Emergency Center Room #:__________
Other (provide address):________________________________________________________
Parent/guardian phone number:_______________________________
Other members of current household:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Gender (M/F)</th>
<th>Relationship to child</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Please list others involved in your child’s care who are not currently residing in the household (i.e. older siblings, non-custodial parent, grandparents, etc.):

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Gender (M/F)</th>
<th>Relationship to child</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

How long has your family been in shelter? ___________________
Has the family experienced previous stays in shelter and/or periods of staying in another relative or friends’ house? Yes_____ No_____ If yes, please describe:
____________________________________________________________________________________
____________________________________________________________________________________

What are your primary concerns regarding your child? _______________________________________
___________________________________________________________________________________
___________________________________________________________________________________

PRESENTING PROBLEMS
Rate problem behaviors on the following scale: (No Problem I Low I Moderate I Serious). Please circle the most appropriate response.

<table>
<thead>
<tr>
<th>Temper tantrums</th>
<th>(N)</th>
<th>(L)</th>
<th>(M)</th>
<th>(S)</th>
<th>Easily frustrated</th>
<th>(N)</th>
<th>(L)</th>
<th>(M)</th>
<th>(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggression</td>
<td>(N)</td>
<td>(L)</td>
<td>(M)</td>
<td>(S)</td>
<td>Attention Span</td>
<td>(N)</td>
<td>(L)</td>
<td>(M)</td>
<td>(S)</td>
</tr>
<tr>
<td>Memory</td>
<td>(N)</td>
<td>(L)</td>
<td>(M)</td>
<td>(S)</td>
<td>Fears</td>
<td>(N)</td>
<td>(L)</td>
<td>(M)</td>
<td>(S)</td>
</tr>
<tr>
<td>Anxiety</td>
<td>(N)</td>
<td>(L)</td>
<td>(M)</td>
<td>(S)</td>
<td>Interrupts Adults</td>
<td>(N)</td>
<td>(L)</td>
<td>(M)</td>
<td>(S)</td>
</tr>
<tr>
<td>Disobedience</td>
<td>(NILIMIS)</td>
<td>Clumsiness</td>
<td>(NILIMIS)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Stealing</td>
<td>(NILIMIS)</td>
<td>Awareness of Danger/ Safety Issues</td>
<td>(NILIMIS)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Fighting</td>
<td>(NILIMIS)</td>
<td>Self-Esteem</td>
<td>(NILIMIS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td>(NILIMIS)</td>
<td>Sleeping</td>
<td>(NILIMIS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fine Motor Control</td>
<td>(NILIMIS)</td>
<td>Gross Motor Control</td>
<td>(NILIMIS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quick Mood Changes</td>
<td>(NILIMIS)</td>
<td>Disturbs Children at School</td>
<td>(NILIMIS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accident Prone</td>
<td>(NILIMIS)</td>
<td>Restless/Overactive</td>
<td>(NILIMIS)</td>
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</tr>
<tr>
<td>Speech/Language (lisp, stutter, speech delay, etc)</td>
<td>(NILIMIS)</td>
<td>Attachment</td>
<td>(NILIMIS)</td>
<td></td>
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</tr>
</tbody>
</table>

**MEDICAL HISTORY**

Please list any illnesses, surgeries, hospital stays, or medical or mental health conditions your child has previously been diagnosed with:

____________________________________________________________________________________
____________________________________________________________________________________

Please list any medications your child is currently taking, including psychiatric medications:
____________________________________________________________________________________
____________________________________________________________________________________

Has your child ever experienced head injuries, been unconscious, had convulsions, a high fever, or was delirious? Yes_____ No_____ If yes, please describe:
____________________________________________________________________________________

How is your child’s vision?
____________________________________________________________________________________

How is your child’s hearing? ______________________________________________________________________

When did your child last have a physical examination? ________________________________________________

Physician’s Name: ___________________________ Phone: ____________________________

Physician’s Address: ________________________________________________________________

**EARLY HISTORY**

Did the mother have any illness or complications before delivery? Yes_____ No____ If yes, please explain: ___________________________________________________________

Did the mother use alcohol or drugs during pregnancy? Yes_____ No____ If yes, please explain: ___________________________________________________________
IT’S THE JOURNEY

Was pregnancy full term? Yes ____ No____ Birth Weight ______lbs _____oz

Were there any complications at birth? Yes____ No____ If yes, please explain: ________________________________________________________________

Apgar Score of health of baby (0-10): ________________________________________________________________

Please Comment on the Following Issues:

Feeding Problems? ________________________________________________________________

Nursed? Y/N Age weaned? ________________________________________________________________

Any physical problems of parents during the first 12 months? ________________________________

Were any household members hospitalized during the first 12 months? _________________________

Post Partum Depression? ________________________________________________________________

DEVELOPMENTAL MILESTONES

Please write the ages at which the following milestones were reached.

Crawled: ____________________ Walked Alone: ____________________

Knew Ten Words: ____________________ Talked in Sentences: ____________________

Completed Toilet Training: ____________________

Is there any history of toileting problems or concerns? ____________________

Temper tantrums: At what age? __________ How Frequent? ____________________

How intense were the tantrums? How were they handled by parents? ____________________

Has your child ever spent time away from the household (i.e. through foster care, placement, etc.?)

Yes____ No____ If yes, please explain: ________________________________________________________________

What your main approaches to discipline with your child?

____________________________________________________________________________________

Which approaches to discipline have shown the most success? ____________________

____________________________________________________________________________________

SOCIAL/EDUCATIONAL HISTORY

School Name: ____________________ Grade: __ Teacher: ________________

Types of classes: ___ Regular ___ Inclusion ___ESE ___EDB (Emotionally Disturbed Behavior) ___Other (please explain):

List previous schools attended with dates: ________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
IT’S THE JOURNEY

Does your child receive special services at school? Yes ____ No ____ If yes, which services and what is the frequency/duration of each?
   ____ Occupational Therapy _____ / week for ____ minute sessions
   ____ Physical Therapy _____ / week for ____ minute sessions
   ____ Speech Therapy _____ / week for ____ minute sessions
   ____ Counseling _____ / week for ____ minute sessions
   ____ Other (please describe): ____________________________________________________________

Has your child ever repeated a grade? Yes ____ No ____ If so, when? __________________________

Does your child have any difficulties at school? Yes____ No____ If yes, please explain: __________
____________________________________________________________________________________

Does your child generally get along with other children his/her own age? Yes____ No____ If no, please explain:
____________________________________________________________________________________

Does child generally get along with adults? Yes____ No____ If no, please explain:
____________________________________________________________________________________

Describe what your child likes to do for fun (special interests, hobbies, etc.): ________________
____________________________________________________________________________________

Does child have unusual sleeping patterns? Yes____ No____ If yes, please explain:
____________________________________________________________________________________

Has child experienced any form of abuse (physical, emotional, sexual)? Yes____ No____ If yes, please explain:
____________________________________________________________________________________

Has child experienced any significant trauma or losses? Yes____ No____ If yes, please explain:
____________________________________________________________________________________

Has child experienced any divorces or separations? Yes____ No____ If yes, please explain:
____________________________________________________________________________________

What are some of your child’s best qualities? ________________________________________________
____________________________________________________________________________________