Questioning “Fluffy”: A Dog’s Eye View of Animal-Assisted Interventions (AAI) in the Treatment of Substance Misuse

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“Fluffy! That’s the word they used to describe our research!” lamented Colleen.

I wasn’t there when it happened, but that’s what I heard Colleen tell her colleague afterwards. I’d like to ask Colleen why she finds the word “fluffy” so offensive, but at the moment I don’t have a way of communicating this to her (Figure 1).

My name is Anna-Belle and I am a 3-year-old St. John Ambulance Therapy Dog living in Saskatoon, Saskatchewan, Canada. I work with Colleen, a Professor and Research Chair in Substance Abuse at the University of Saskatchewan. Last year, Colleen took a research sabbatical to study animal-assisted interventions (AAIs) as “an innovative approach to human health,” with a focus on healing from substance misuse. Her calling it innovative is interesting to me. I think that what she’s studying is simply the way it is. People need to connect with other people, animals and nature to achieve a sense of balance and state of wellness and with all its ups and downs. As a dog, I know that I do.

Colleen talks about things like the “biophilia” and “nature-deficit disorder” hypotheses to explain what I know with every fiber of my being. Biophilia suggests that based on an evolutionary past, humans need to attend to the modern split between nature and their spirit so they can feel healthy (Wilson, 1984). Today people like environmental activist David Suzuki espouse it. Nature-deficit disorder has been suggested by Louv (2008) to describe a lack of sensory experience interacting with the natural world. Children need this for healthy development.

Colleen has also been talking a lot recently about One Health¹. This public health framework suggests that to achieve optimal human health, the interactions among humans, animals and the environment need to be considered. She specifically bears in mind the concept of *zooevia*, the benefits of animals to human health (Hodgson & Darling, 2011). I have met Indigenous Elder Campbell Papequash from Key First Nation in Canada, who Colleen works with. He knows all this already, and more (Papequash, 2011). Traditional

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Declaration of Interest

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¹“The One Health concept is a worldwide strategy for expanding interdisciplinary collaborations and communications in all aspects of health care for humans, animals and the environment” (One Health Initiative). It is rooted in “comparative medicine” of the 19th century, and more recently what Calvin Schwabe termed “one medicine.”

Indigenous people in Canada view the world as interconnected, seeing human wellness as “connection to language, land, beings of creation, and ancestry, supported by a caring family and environment” (Dumont, NNAPF & HOS:CasI, 2014).

Colleen is also learning by working with me, and I think she realizes this more each day.

When Colleen started her sabbatical, she and I trained together and then we tested for and passed the therapy dog test. I had to show two things—that I was well-behaved and that I liked visiting people. Done and done. Colleen brought a wheelchair into our house for a month before the test, along with some crutches, and she made lots of loud noises so I could get used to different experiences. She also took me off our quiet acreage, where I felt the safest, and introduced me to the big city of Saskatoon. I was young, just over a year old. I learned to trust Colleen a lot.

Soon after, Colleen and I traveled to Illinois in the United States for 2 weeks of dog psychology training. We flew on a plane, slept in hotels, drove for a few days in a truck, and trained, trained, trained, and trained some more. But it wasn't me so much that was getting trained this time. It was Colleen. She was learning to communicate with me. They asked her at the start of her class to consider whether she would still love me when she learned about who I really was. She didn't understand the question but I did. By the end of the 2 weeks she did too.

In fact, she says now that not only does she love me but she really respects me. This is how I heard her explain it to a friend of hers: “You know, I used to think that I was a good pet owner. And that is exactly how I approached my relationship with Anna-Belle, like she was my property. I now recognize that I have a sentient cohabitant in my home, a companion animal. And I marvel at how she is able to live so well in it, since I still know very little about how to communicate with her species. For example, when I was teaching her to skateboard I remember watching a video of me saying ‘skate, skate, skate’ about eight times in 10 seconds. Once I realized that she does not process information that quickly, and that she is not just being a stereotypical stubborn bulldog, things changed. I said it once, counted to eight, and wouldn't you know it? Down went her leg and she started to skate. That was a significant ‘aha’ moment for me” (Figure 2).

When we got home from Colleen's training, we started to visit lots of people. She said we were “going to work” but to me, I was simply visiting people. In fact, I think we have visited for over 300 hours now, at addiction treatment centers, prisons, hospitals, a methadone clinic and other places. The aim of the St. John Ambulance Therapy Dog program is to offer the people we visit love and support. During these visits Colleen has been witness to what she describes as “some remarkable moments with Anna-Belle.” I don't know what was so remarkable about them. I was just being me, doing what I do naturally, living in the moment.

Colleen uses words like “establishing a bond,” “therapeutic alliance,”² “comforting,” “practicing fine motor skills,” “bringing calmness,” “offering motivation,” and “a form of nonjudgmental social interaction” to describe what I do.

Once, we were at an addictions treatment facility in a 20-minute one-on-one session. The individual we were visiting that day came into the room and hugged me. She kept hugging me and petting me and I had no problem with that at all! Colleen asked her a few questions, but not much talking was going on. And then toward the end of our time together, the woman said “You know, I just lost a member of my family, and I feel so sad. You make me feel better”. She wasn’t talking to Colleen.

Another time we were at a prison, and the inmate coming to see me shuffled into the visiting room looking sad and anxious. I tried to show him that I was happy to see him in my dog ways. He proceeded to lie on the concrete floor. So Colleen got a blanket, and I lay beside him. He pet me for 20 minutes. He smiled lots at me and I smiled back. His prison worker said it was really good to see him so content and maintain steady eye contact with me, because he has a very hard time looking people in the eyes (Figure 3).

At another residential addiction treatment facility, we visited a group of about 12 people. I was there visiting everyone but there were two people I was particularly drawn to. I knew why, but Colleen didn’t. I visited with these two people a lot. One of them got off their chair and kissed and cuddled me. After our visit, the treatment counselor told Colleen that these two people were suffering particularly badly that week from traumatic memories. He and Colleen found it really interesting that I paid extra attention to them. I didn’t – I know what I am doing and why. I guess that is what Colleen is trying to figure out with her research.

Some would say that these are just “fluffy anecdotal stories,” and not “proof” that animals can help people’s healing from substance misuse. Colleen and her team received a national Canadian Institutes of Health Research grant to study how human experiences of trauma, coped with through substance misuse, can be addressed with AAIs. Hers is just one study among the growing base of empirical evidence in the general AAI field these days. Even comparison studies are happening where some people receive an AAI and others do not, and the difference in what happens is measured. One study by Havey, Vlases, Vlases, Ludwig-Beymer, and Hackbarth (2014) found that “daily visits with a specially trained dog – even for just five minutes – can significantly reduce the need for pain medication in patients recovering from joint replacement surgery” (Anson, 2014). Others are studying post-traumatic stress disorder, measuring AAI’s impact on cortisol (stress) and oxytocin (feel good) levels in veterans returning from war. (See, for example, the work of Krause-Parello, 2014) Several studies identify how simple social interaction with a dog can decrease cortisol and increase oxytocin levels in people (Handlin et al., 2011; Miller et al., 2009).

Colleen and other researchers think that we have enough stories to move beyond the question of “if” AAIs are beneficial to human health and can start to look at the question of “how.” She said we need to consider the past too as the research moves forward. It’s like the story I heard Colleen telling some of her colleagues. When methadone was first given to

²Concepts representing such processes as *treatment engagement/alliance* and *treatment adherence/compliance* are often used in the literature without adequately noting their dimensions (linear, nonlinear), their “demands,” the critical conditions (inner and external ones, including relevant needed resources) which are necessary for any of them to operate (begin, continue, become anchored and integrate, change as de facto realities change, cease, etc.), and their underpinnings (theory-driven, empirically based, individual and/or systemic stake holder-bound, based upon “principles of faith,” etc.). They are commonly related only to the *identified patient* and do not consider the treatment agent, whoever they are, or the agency.

people addicted to heroin in New York City in the sixties, there was a lot of criticism. People forgot that after World War One, 43 clinics in the USA treated people with opiate addictions. They were closed because of influential people's beliefs and agendas – not because of the facts (Terry & Pellens, 1928). People have funny ways of thinking. Many new studies, some in the field of substance misuse, are underway, with more planned for the future. I hope someone investigates how to best incorporate emerging understanding into programming and interventions.

Colleens says that we have to make sure though that we don't continue with some of the potentially flawed thinking in the treatment field. Things like conceptual flaws, where people tend to think that there are known and approved treatment techniques that guarantee human recovery. There is also the disease model flaw, where people who are suffering from misuse of substances are only seen as sick, and consequently their strengths are downplayed. And then there is the resource flaw. How can we address substance misuse and its impact on all of us without spending lots more money?

I have an idea. Some AAI studies specific to substance misuse can be a starting point. It seems that humans foremost listen to other humans, so I think it would be useful to start with a focus on the human therapist. A quantitative study by Wesley (2012), using randomized populations and controlled conditions, concluded that the presence of a therapy dog increased the therapeutic alliance in an adult residential substance-user population in group therapy. A qualitative case study in an equine-assisted learning program with Indigenous female youth in treatment for volatile substance misuse by Adams et al., (2013) identified that the program facilitators were an essential part of the program's impact on the youths' well being.

I think I have said enough now for my first ever written piece of work. Well, maybe one more thing. I don't think Colleen should be offended by the word "fluffy." I am a dog and therefore naturally fluffy. In fact, I think it is in part because of animals' fluffiness that AAIs have the impact they do. I also think that Colleen's use of the word "innovative" to describe her team's AAI research may not be all that bad after all. You know the human saying that goes something like same old product just new packaging? From this dog's eye view, it seems to me that humans gravitate toward things that are new. Colleen speaks about age-old practices – like music, meditation, labyrinth walking and mindfulness – being introduced into the treatment of substance misuse³ these days as new approaches. Maybe repackaging me is how we can move the AAI field forward.

³Treatment can be briefly and usefully defined as a unique, planned, goal directed, temporally structured, multidimensional change process, of necessary quality, appropriateness and conditions (endogenous and exogenous), which is *bounded* (culture, place, time, etc.), associated with a range of stakeholders with agendas, and can be categorized into professional-based, tradition-based, mutual-help based (AA, NA, etc.) and self-help ("natural recovery") models. There are no unique models or techniques used with substance users—of whatever types and heterogeneities—which aren't also used with nonsubstance users. *Whether or not a treatment technique is indicated or contraindicated*, and what are its selection underpinnings (theory-based, empirically based, "principle of faith-based," tradition-based, etc.) continues to be a generic and key treatment issue. In the West, with the relatively new ideology of "harm reduction" and the even newer Quality of Life (QOL) and wellbeing treatment-driven models there are now new sets of goals in addition to those derived from/associated with the older tradition of abstinence driven models. Conflict-resolution models may stimulate an additional option for intervention. Each ideological model has its own criteria for success as well as failure as well as iatrogenic-related harms. Treatment is implemented in a range of environments; ambulatory as well as within institutions which can include controlled environments. Treatment includes a spectrum of clinician-caregiver-patient relationships representing various forms of decision-making traditions/models; (1) the hierarchical model in which the clinician-treatment agent makes the decision(s) and the

I think I should be repackaged as a scientist, because I have a lot to teach humans if they are willing to listen and hear, look and see. Just ask Colleen (Figure 4).

FOLLOW-UP

You can follow my continuing adventures with AAIs on Facebook at: <https://www.facebook.com/AnnaBelle-SubiesAdventures>

You can watch a video of me working with Colleen that was produced by SaskTel Max magazine: <http://www.youtube.com/watch?v=OerloKDBpYg&feature=youtu.be>

You can also visit Colleen's research website at: <http://www.addictionresearchchair.ca/>

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recipient is compliant and relatively passive, (2) shared decision-making which facilitates the collaboration between clinician and patient(s) in which both are active, and (3) the "informed model" in which the patient makes the decision(s). Editor's note.

Biographies

Anna-Belle is a St. John Ambulance Therapy dog living in Saskatoon, Saskatchewan, Canada. She is a 3-year-old bulldog who has a passion for people, nature, and skateboarding.

Colleen Anne Dell, PhD, Canada, is Professor and Research Chair in Substance Abuse at the University of Saskatchewan in the Department of Sociology and School of Public Health. She is also a Senior Research Associate with the Canadian Centre on Substance Abuse. Her research program is grounded in an empowering, community-based participatory approach and draws upon her extensive front-line experience in the field.

FIGURE 1.
Me and Colleen.

FIGURE 2.
Me and my vintage skateboard.

FIGURE 3.
Me smiling.

FIGURE 4.
Me with my science goggles on.