**A CBT APPROACH COMBINED WITH ANIMAL-ASSISTED THERAPY TO TREAT DEPRESSED ADOLESCENTS**

by

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## Abstract

The thought behind this program development for adolescents emerged due to the rise of depression over the past decade. It is this writer's belief that with the increase of population, social media, peer pressure and body image among young girls, those issues have all contributed to low self-esteem and low self-confidence which have led to a greater diagnoses of depression. There have been many professionals that have developed traditional therapy programs, but it is my belief that if we can help teens connect with life through love and compassion, then they can overcome their depression long term with an additional tool for maintaining a healthy mental life style. This program will allow the teen to get out of a traditional office setting and contribute to the welfare and future of abandoned canines that need love, care and assistance in finding a forever home. When most teens become depressed they feel useless, lonely, anxious and fearful of facing everyday tasks. The thought behind this program is to allow them to focus on an animal's well-being and experience the special and magical connection humans and animals develop. The hope is that this could help them through the most difficult stage of life and strengthen mental health for future success. This study will look at developing a program that will introduce animal-assisted therapy and cognitive behavioral therapy with fundamental beliefs of Attachment Theory for the treatment of adolescent females diagnosed depressed.

Dedication

I dedicate this dissertation to my wonderful children, Hunter, Tyler and Karlee. When we become mothers a completely new love develops, a love that we could never understand. Throughout this journey all three of my children have been my biggest support while encouraging me to keep moving forward and pushing through the tough parts. It's the love of my children that led me to take this path and work hard to become the best I can be in every aspect of life. Living through my own sons struggle with ADHD and Dyslexia, has given me the strength and determination to help other children and parents who are struggling with the similar issues. I dedicate this dissertation to my father, Donald for always instilling in me personal strength, dedication toward goals, unconditioned love and confidence in myself. You always guided me through life struggles while supplying spiritual faith and hope. I grew up in a very small country community, which allowed me to connect to nature and develop my love for animals. This experience has made me the person I am while allowing me to develop the magical connection we as humans have with other species. I would like to include my sister Lisa for always being my rock, my person and best friend. During this journey, I lost my sister to cancer and this has given me a new meaning of life and a determination to begin each day with an appreciation for life and to just make the world around me better. I would like to dedicate it to my niece Alisa for cheering me on, encouraging me and going out of her way in helping me when I needed her. I dedicate this work to some very special friends some have been with me on this journey from the beginning and some joined me along the way, Jamie, Debbie, Linda

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# CHAPTER 1. INTRODUCTION

Major depression has increased as one leading disorders in the adolescent population with recurrent and extended episodes (Shirk, DePrince, Crisostomo & Labus, 2014; see also Klein, Torpey, & Bufferd, 2008). In 2014, "an estimated 2 million adolescents aged 12 to 17 in the United States had at least one major depressive episode in the past year with severe impairment, while this number represented 8.2% of the U.S. population aged 12 to 17" (National Institute of Mental Health, 2014, p. 1). There has been a rate of increase number of adolescence being diagnosed with depression with a great number of gender differences as well (Hankin, et al, 2015; see also Avenevoli, Swendsen, He, Burstein, & Merikangas, 2015; Costello, Copeland, & Angold, 2011; Hankin et al., 1998). Stark, Banneyer, Wang and Arora (2012) and SAMHSA (2009) reported that "during adolescence, there is a sharp increase in the prevalence of depression among female individuals to nearly a 3:1 ratio compared with their male counterparts" (p. 1).

Stark et al. (2012) explains that treatments for adolescent depression are primarily psychopharmacological or based on cognitive theory addressing distorted thinking patterns, but some have found treatment to be more effective when the family becomes involved. Those treatments could vary from many types of interventions such as parent training to family therapy (Stark et al., 2012). The best effective treatments for youth have been seen with (CBT) cognitive–behavioral therapy or (IPT-A) interpersonal therapy for adolescents in multiple formats that have included group or individual

sessions (Stark et al, 2012; see also Lewinsohn, Clarke, Hops & Andrews, 1990; Clarke, Rohde, Lewinsohn, Hops, & Seeley, 1999; Rosselló & Bernal, 1999).

Considerable research shows that deficits regarding poor attachments in infancy is tied back to the cause or development of depression in adolescence (Parish-Plass, 2008). The key goal of this proposed study will be focused on incorporating an attachment based intervention with a cognitive based intervention. It is hoped that this method of treatment will provide relief from the symptoms of depression that lasts long into the future.

The program proposes a dual treatment for depression in adolescent girls that includes cognitive behavior therapy and canine-assisted therapy; however, unlike the traditional therapeutic process, this study will incorporate canine therapy into its therapy process. Cognitive based therapy which includes an assigned pet will be conducted in the therapist's office. The program focus involves alleviating depression while improving attachment patterns by addressing cognitive distortions and tending to an animal with needs for compassion and love. This program focuses on Bonding With Animals with Compassion for Knowledge to Live Indefinitely for Excellence, BACKtoLIFE.

**Background of the Problem**

There are clear developmental forms beginning from childhood through adolescence of depression that can become incapacitating (Hankin, Young, Abela, Smolen, Jenness, & Gulley, 2015). "Behavioral genetic research indicates significant, albeit moderate, heritability for depression, and this genetic effect increases among older adolescents, mostly in stressful environments" (Hankin et al., 2015, p. 2; see also Rice, Harold, Thapar, 2003; Silberg et al., 1999; Uher & McGuffin, 2008, 2010). Hankin et al.

(2015) explains how genetics along with development and stress can all play a role in the possibility of developing depression. When children reach the pubertal stage it brings forth changes biologically, emotionally, mentally, and behaviorally, therefore the study of the pubescent phase has been considered as a relevant impact with depression (Hankin et al., 2015; see also Hayward, 2003; Ladoucuer, 2012).

## Statement of the Problem

The main purpose of BACKtoLIFE was to design a new and innovative way to conduct therapy within the female adolescent population with the hope of reducing relapse frequency of the treatment of depression.

Current effective treatments for depression in adolescents are based on cognitive theory. Research shows their effectiveness in the short term but relapse is frequent. Some treatments combine CBT with other therapies in an attempt to extend the effectiveness of the treatments. For example, Watson, Gordon, Stermac, Kalogerakos and Steckley discussed "that the focus on their study was to examine the differential effectiveness of cognitive-behavioral therapy (CBT) and process-experiential therapy (PET) in the treatment of major depression" (2003, p. 1). Their technique PET was designed to resolve clients' cognitive-affective problems in therapy by assimilating several methods such as gestalt and client-centered techniques (two-chair, empty-chair, systematic evocative-unfolding, and focusing) (Watson et al., 2003). This program is designed to advance the treatment of depression through needs, compassion, hope, and individual assessment with emotional growth.

When exploring depression within the adolescent population, attachment theory can describe the development of a strong understanding of the importance of a healthy and natural bond needed from infancy. Stark et al. (2012) explains that "from a systems perspective, reciprocal relationships exist between the child, his or her parents, family, and other contextual variables to impact the etiology, evolution, and resolution of problems such as depressive disorders" (p. 2).

Animals have been included in the therapy process with good results in improving attachment patterns. Through years of research a host of positive affirmations between animal-human relationships increases human's well-being and health (Schramm, Hediger & Lang, 2015).

This study will look at the connection between attachment status and adolescent depression, with the hope that integrating canines into the therapy process may extend the effectiveness of treatment. The proposed program will integrate cognitive and attachment theories to develop an integrated therapy for female adolescents diagnosed with depression.

BACKtoLIFE addresses the question: Can CBT and Canine Assisted Therapy be integrated into a new approach to treating depression in adolescent girls?

## Program Development

BACKtoLIFE includes components of CBT and Canine Assisted Therapy combined into a single, integrated therapy for depression and anxiety in female adolescents but consists of no data collection. The foundation will be evidenced from peer-reviewed journal articles and theoretical orientations supported by evidence-based

practices. Review, research and cross comparisons will be analyzed in order to support the need for a program that could bring about a lasting recovery regarding treatment for depression. Assessment measures with strong reliability and validity are essential to determine the usefulness and success of this program.

While developing this program it will be important to look at current and past research to add to the need and purpose of designing a new program to add to the legitimacy of concern of the rise of depression and distress in female adolescents. The past research will assist in developing a need for a program with more extensive efficacy for treatment. Introducing past research can add to the importance of combined treatments within the adolescent population with rising depressive disorders.

## Need for the Program Development

The purpose of the dual therapeutic program is to expand and develop additional methods for treatments with the adolescent populations that develop depression for improvement in their future. The goal is to allow participants in the program to experience therapy on a different level by including Canine Assisted Therapy to help expand their knowledge regarding their own strengths and open their senses to attachments through bonding with an animal in need. By incorporating CBT, the program will address dysfunctional thinking and explore cognitive distortions. BACKtoLIFE will add to the therapeutic process for female adolescents diagnosed with depression and those attachment issues that go hand in hand with depression. There are many depressed individuals that are diagnosed with anxious distress; therefore, we will assess each participant that may meet that added criteria.

Assessment of objectives with possible outcomes.

Table 1. An Explanation of Measures Designed to Assess Program Objectives

| What is being Measured | Measures of Program Objectives |
|---|---|
| Group/Gender | Ages 13-17 Females with Emotional Distress, Any ethnicity or race. With family support and agreement to follow and meet all requirements for program. |
| Program Development Objective | To provide a therapeutic process that explores cognitive distortions and attachments with animal bonding. Applying Measurements that keep track of their progress, *Beck Depression Inventory, 2nd Edition* (BDI-II), *The Reynolds Adolescent Depression Scale-2* (RADS-2) |
| Depression | Depression and possible anxiety and a measure if they present with anxious distress, *State-Trait Anxiety Inventory* (STAI) |
| Attachment | Complete family history with added assessments if trauma has been established. *Family Assessment Measure* (FAM III). Inventory of Parents and Peer Attachment-Revised |
| Expected Outcome | Longer efficacy of treatment with depression. Learning to build relationships, experiencing bonding, contributing to the wellbeing of another and developing a self-worth. Success |

*Note.* A duel therapeutic program, objectives, methods of assessment and objective outcomes.

The focus of BACKtoLIFE will be building an ability to connect with another being on an emotional level that may have never been experienced, reducing relapse frequency of depression, build self-worth, and develop concepts that show them a positive future while building healthy attachments. The overall goals for BACKtoLIFE are as follows:

The use of CBT will address dysfunctional thinking and/or redirect cognitive distortions. Improving cognitive skills of dysfunctional thinking can turn into positive

self-regard which leads to healthy decision-making skills. The use of animal assisted therapy will help in developing healthy attachments, bonding skills and self-awareness abilities. Through developing healthy relationships by experiencing bonding of animals will allow them to move forward with positive outlook for their future.

While setting goals is imperative, the purpose of developing BACKtoLIFE is to improve therapeutic success in treatment of adolescent girls diagnosed with depression. It will address the development of healthier thinking, and open pathways to more secure attachment, thereby providing longer symptom relief from the depression. This program will provide social interaction while connecting relationships to actions and thoughts.

## Significance of the Program Development

The development of BACKtoLIFE will focus on longer symptom relief and emotional wellness from the combination of CBT and Canine Assisted Therapy in depressed female adolescents. It will support all components with literature and evidence based practices while designing an evaluation plan. The evaluation plan will consist of self-measured assessments, measures of cooperation of shelter staff and other professionals within the community, and of family members, so the participant can meet all requirements. The evaluation plan will measure psychological distress pre therapy, midway and post therapy for an outcome measure of the program. The plan will incorporate feedback from parents, participants and therapist regarding their thoughts of the level of success. Lastly, one of the most important aspects of the evaluation plan will be in assessment measuring of the effectiveness of BACKtoLIFE.

## Assumptions and Limitations

The assumption of this program design is that combining CBT and animal assisted therapy will improve the treatment of depression in the female adolescent population by implementing healthier thinking, by addressing dysfunctional thinking patterns, and developing more secure attachment skills through bonding with animals.

Some limitations with this program are the need for a strong commitment to see the program through to the end because the wellbeing of the canine is part of the process; family members that are involved will need to be fully committed; and this program would not benefit anyone that has a fear of dogs. In addition, there is limited literature that support this treatment combination. Additionally, consent forms will need to be signed that relinquishes the shelter or therapist from responsibility for any damage from the animal and that participants will abide by all legal and ethical standards set forth at the therapeutic site.

## Definition of Terms

When speaking in terms of psychology it would be essential to define specific terms for a more accurate understanding in regards to person, emotions, and treatment techniques. When we speak of populations, gender, emotions, and mental health disorders it would be more advantageous to define them in terms that relate to BACKtoLIFE. For the purpose of the BACKtoLIFE, the adaptations of the following definitions and terms are cited directly from specific journal articles regarding that term.

***Animal-Assisted Therapy (AAT).*** Animal-Assisted Therapy (ATT) is defined as "a type of psychotherapy employing the presence of animals within the therapy setting, addresses these issues and provides avenues for circumventing these difficulties, as well

as providing additional tools for reaching the inner world of the client" (Parish-Plass, 2008, p. 2). This program will define AAT as a way to close the gap on attachments and interpersonal struggles. This program is designed for all species that can be used in the therapy process such as horses, cats, pigs, dogs and many others.

***Attachment.*** Attachment is defined by "the fact that it depends upon the development of appropriate mental representations, or what Bowlby refers to as internal working models, of the parent–child relationship" (Parish-Plass, 2008; Bowlby, 1969, p. 4). Attachment is defined in this program as a maladaptive formed relationship, rather with parent, family or friends. Herbert, McCormack and Callahan (2010) & Summers (1994) explains that as the result of early attachment experiences that lead to recurrent issues surrounding insecure attachment styles, an assertion that many object relations theories adhere to.

***Bonds.*** Bonds are defined as "the evolution of human-animal bonds, reviews research on their health and mental health benefits, and examines their profound relational significance across the life course" (Walsh, 2009, p. 1). Bonds are defined in this program as an unbroken trust and relationship that can be built on and remain for future security, rather it is between animal-human or human-human.

***Canine-Assisted therapy.*** Canine-Assisted therapy brings the power of touch and affection into the therapy setting that therapists can't provide. The presence of a dog can help therapy clients tap into and express blocked, difficult, and painful thoughts and emotions. Therapists can use therapy dogs to model healthy social interactions. Therapists can use the interactions between their clients and the therapy dog as a

springboard for discussion, as well as to gain valuable insight into the client. This program will focus only on canines (dogs) (Canine assisted therapy, 2015).

***Cognitive Behavioral Therapy.*** Cognitive Behavioral Therapy is defined as "a highly effective evidence-based therapy for a wide range of psychological problems and is deemed to be an empirically supported first line treatment for many disorders" (Mothersill, 2016; see also Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012; Hunsley, Elliott, & Therrien, 2014). This definition applies to the same meaning within this program and follows a traditional path in CBT therapy. Part of CBT is recognizing distorted cognitions and then implementing new skills to improve that negative thinking pattern.

***Depression.*** Depression is defined "by DSM-5 as a period of time of depressed mood, loss of interest or pleasure, in nearly all activities" (APA, 2013). Frictional parental relationships from nonexistent support, opposition, resentment, and non-communication are several causes of depression in children and adolescents while causing continued episodes (Dietz  et al., 2014; see also Birmaher, et al., 2004; see also Sheeber, Hops, & Davis, 2001; Sheeber, Hops, Alpert, Davis, & Andrews, 1997). This program will look at depression in many aspects. Depression can develop for many reasons but this program will focus on dysfunctional thought patterns that have emerged into all areas of a female adolescent's life from, personal, academics to social.

## Expected Findings

The expected findings of Bonding with Animals with Compassion for Knowledge to Live Indefinitely for Excellence, BACKtoLIFE will be developing longer symptom

relief of the treatment of depression. The hope is that this program can be included as a more innovative treatment to address dysfunctional thought processes and the experience of building strong and healthy attachment relationships and/or bonds for depressed adolescents. By combining CBT and Canine Assisted Therapy, the participant will learn and experience how to develop healthy attachments, experience bonding and learn to trust others and themselves. This program will instill and provide skills in positive thinking, which will lead to positive actions to develop for future endeavors.

This dissertation entitled *An CBT approach combined with animal-assisted therapy to treat depressed adolescents* is not based on implementation but on the designing of the program. The program's logic model design will measure the anticipated outcomes of BACKtoLIFE upon implementation. The BACKtoLIFE outcomes will be anticipated based on the past and recent literature regarding the female adolescent population diagnosed with depression but possibly with some anxious distress, cognitive and attachment deficits as theoretical foundations.

## Organization of the Remainder of the Program Design

The remainder of the development program design BACKtoLIFE will contain the literature review, background information, program design, program development, and recommendations sections. Chapter 2, the literature review, consists of the introduction, theoretical orientation, research literature, methodological literature, research question, and summary. Chapter 3, the program design, encompasses the target population, participant selection, admission criteria, exclusion criteria, assessment measures, dismissal policy, and clinical staff qualifications. Chapter 4, the program development, consists of characteristics of effective program intervention, target population

(adolescent females), program implementation, program budget, program evaluation, program location, and summary. Chapter 5, the recommendations section, includes the recommendations for future research to demonstrate the effectiveness of the interventions, and implementations of the BACKtoLIFE.

# CHAPTER 2. LITERATURE REVIEW

## Introduction to the Literature Review

In developing the BACKtoLIFE program, the researcher conducted a comprehensive examination of the literature covering theoretical framework of the program, literature significant to the topic of exploration, an overview and evaluation of present programs, and a short synopsis of the literature. Accordingly, this review covers the components of the cognitive and attachment theories as well as previous research with regard to depression in adolescent females and the current state of treatment. Additionally, the researcher also explored the link between canine assisted therapy and CBT as paired components of treatment. Academic, peer-reviewed journals, evidence-based treatment, and information regarding animal therapy were examined and used as a foundation for the development of the BACKtoLIFE program. The outcome measures identified in the evaluation of this program were investigated similarly. The journal articles, books, and other references offered in this study contains information related to theories of depression, cognitive and attachment perspectives and the use of animal therapy.

The researcher utilized PsycINFO, PsycARTICLES, Proquest, and Google Scholar, when conducting the literature review. A review of the research revealed that the pervasiveness of depressed children and adolescents is rising due to many negative aspects of their environment. Consequently it was relevant to explore not only causes, but also the efficacy of current treatments. Although the literature supported the magnitude of early diagnosis and treatment of depression in children and adolescents,

there are no outpatient treatment programs identified that combined CBT and therapeutic interaction with animals.

## Depression in Female Adolescents

Despite the alarming increase in the prevalence of depression among adolescents, particularly among females, the extent and depth of depression in adolescence is unknown (Auerbach, Stanton, Proudfit, & Pizzagalli, 2015). Kendall (1993) express how the current estimates of the increase of psychopathology of depression in children in the United States are alarming. Specifically, "recent epidemiological data suggest that between 15% and 22% of the nation's approximately 63 million youth have mental health problems severe enough to warrant treatment" (Costello, 1990; see also National Advisory Mental Health Council, 1990). Research suggests that the lifetime prevalence for adolescent major depressive disorder (MDD) is 11.7% (Auerbach et al., 2015; see also Merikangas et al., 2010).

Stark, et al. (2012) assert that "depression is a significant mental health concern among youth" (p. 1). Auerbach, et al. (2015) and Rudolph (2009) explain that the development of depression is associated with developmental, social, and behavioral problems. Developmentally adolescents can struggle with gender, physical, and health issues that constrain their abilities to function in society. Socially, adolescents can develop peer pressure, loneliness, feelings of being an outcast or struggle to feel needed or wanted in social settings. Behaviorally, adolescents can begin to make poor choices that lead to drugs, alcohol, sex and aggression while becoming at risk for developing depression (Auerbach et al., 2015).

Feelings of worthlessness and helplessness, in addition to behavior and brain

activity driven by negative overall beliefs, are core symptoms of depression (Auerbach, et al., 2015; see also Auerbach, Ho, & Kim, 2014). Auerbach et al. (2015) found that specific neurological and environmental factors contribute to female adolescents having an elevated risk for developing depression. During this stage of life, the demands on adolescents to comply with adults, achieve peer acceptance and cope with negative family environments, render them vulnerable for developing depression.

It has been reported "that during adolescence, there is a sharp increase in the prevalence of depression among female individuals to nearly a 3:1 ratio compared with their male counterparts" (Stark et al., 2012, p. 2; see also SAMHSA, 2009). Research reasonably supports that children who have developed depression is highly likely to struggle with depression in adulthood of long-term functional disability (Stark et al., 2012; see also Weissman et al., 1999). As such, this program was designed to lessen the chance that adolescent girls will carry depression into adulthood by developing a therapeutic process, based on combined theoretical techniques, in the hope that their depression can be managed and controlled before entering into adulthood.

The National Institute of Mental Health Information Resource Center (2015) provided a 12-month Prevalence of Major Depressive Episode Among U.S. Adolescents, in which they found that females are much higher with 19.5 percent compared to males at 5.8 percent. Regarding females the highest rate for age is 15 to 16 years, with Caucasian (13.4%) and Hispanics (12.6%) being the highest among races that are affected (The National Institute of Mental Health Information Resource Center, 2015).

## Theories of Mechanisms Underlying Depression

"The mechanisms underlying the surge in rates of depression from late childhood through adolescence are not well understood, although several theoretical models have been proposed" (Hankin et al., 2015, p. 6). Many theories propose that various vulnerabilities potentiate symptoms of depression triggered by traumatic or tense life events, especially relational or social events of the development of depression with adolescence. (Hankin et al., 2015; see also Cyranowski et al., 2000; Hankin & Abramson, 2001; Nelson, Leibenluft, McClure, & Pine, 2005; Oldehinkel & Bouma, 2011). Several of these theories will be explored in the following sections.

## Cognitive Theories of Depression

According to Cognitive theorist those with cognitive vulnerabilities are more likely to develop depression with stress or faced with traumatic experiences (Carter & Garber, 2011; see also Abramson, Metalsky, & Alloy, 1989; Abramson, Seligman, & Teasdale, 1978; Beck, 1967; Brown & Harris, 1987). Regarding the theory of cognitive therapy in this program, Carter and Garber (2011) proposed that the cognitive vulnerability hypothesis, "suggest that some individuals are more likely to develop depression in the face of stressful life events due to their interpretations and expectations of the meaning of the events with regard to their lives" (p. 2). For this proposed program this theoretical makeup of cognitive vulnerabilities will guide specific weaknesses that cause depression. Specifically in their present study, theories that drive to explain the cause of depression fixate on negative cognitive experiences (Carter & Garber, 2011; see also Garber, 2007). Subsequently, most like Beck's cognitive theory (1967), self-worth and the way one perceives experiences are essential to understanding cognitive

vulnerabilities which lead to depression, in which theories are built upon through additional research (Carter & Garber, 2011).

Auerbach et al. (2013) suggest additional thoughts and feelings about how cognitive vulnerabilities bring to light the vulnerability of depression in adolescents using the thoughts of other theories. These models have laid down a conceptual roadmap in predicting the onset, severity and reoccurrences while suggesting the need to search further the neurobiological and behavioral aspects that underline core factors of cognitive vulnerabilities (Auerbach et al., 2013). Bieling & Grant (2007) clarifies explicitly how "depression is a complex disorder that can take many forms with respect to factors such as symptomology, duration of episodes, course, and contributing environmental factors" (p.1). In this clarification they tie cognitive vulnerabilities into a prediction of a characteristic that predisposes a person to develop symptomologies of depression (Bieling & Grant, 2007).

Cognitive theories have been developed in an effort to satisfy multiple criteria and to avoid theoretical bias, 13 criteria's have been identified that the human cognitive architecture would have to be satisfied in order to be functional (Gelepithis, 2003; Newell, 1973, 1980, 1990). When these criteria are not met or misinterpreted, mental disorders can emerge, such as depression. Gelepithis (2003) condensed "specific criteria into the following: flexible behavior, real-time performance, adaptive behavior, vast knowledge base, dynamic behavior, knowledge integration, natural language, learning, development, evolution, and brain realization" (p. 1). Each of these factors can influence behavior depending upon how an individual interprets the world around them and those experiences they encounter. In addition, the theory of cognition should explain the great

flexibility of human perception, as well as how humans function in "*real*" or human time (Gelepithis, 2003). As such, depending on a person's environment, behavior, and experiences, he or she can develop negative cognitions which may lead to depression. During times that one experiences negative cognitions (negative thinking), they are more vulnerable to develop symptoms that allow behaviors to emerge and become habitual feelings, such as depression. Gelepithis (2003) explained that there have been constrictions on the amount of time needed in understanding of the neurological foundations of human cognitions and behaviors that emerge due to how they cognitively integrate their experiences.

Although some theorists propose slightly different criteria needed for a stable emotional mental state, others focus on the cognitive vulnerabilities in a person that lead to depressive symptomology (Auerbach et al., 2013). Auerbach et al. (2013) in searching for explanations of cognitive vulnerabilities some authors have thoughts that dysfunctional attitudes, negative thought processes, core beliefs that emerge from negative experiences, and information processing difficulties contribute to predisposition of depression.

## Attachment Theory of Depression

Attachment Theory was developed in the hope of explaining how human development can be affected through touch, emotions, and the need of human experiences. A specific theory was developed from normal and abnormal development to provide understanding, known as the Attachment Theory to provide a developmental psychopathology approach (Connors, 2011). "Early in infancy, the child has an essentially symbiotic relationship with the caregiver and has primary needs for

sustenance, love, and physical contact with the caregiver" (Kopala-Sibley, Zuroff, Leybman & Hope, 2012, p. 2; see also Blatt, 1974). Kopala-Sibley et al. (2012) stressed that when attachment is not met due to a poor relationship, a child's ability to develop stable internal representations of the caregiver as loving, caring, and available, may become impaired and this pattern is repeated in later relationships. Ainsworth (1989) explained that an emotional bond is essential while developing a relationship with a specific individual in close proximity such as an attachment relationship (Connors, 2011). Hence, a healthy attachment from infancy can provide a shield that can rebound negative cognitive growth and interpretations. During the treatment of depression in many cases, family member's participation is important due to predictions and research that finds environmental disturbances such as stressful events and stressed interpersonal relations cause the development of depression (Stark et al., 2012, p. 2). Many researchers found "that impaired social and interpersonal skills and/or specific symptoms of depression may inhibit depressed parents' abilities to appropriately engage with, and meet needs of, their children" (Stark et al., 2012, p. 2, see also Restifo & Bögels, 2009).

The attachment system strives to promote proximity to parents or guardians in the service of attention and safety such as the consistent relationships the adolescent experiences that leads to their perception and emotions of negative or positive attachment figures (Cawnthorpe, West, & Wilkes, 2004). More specifically, "repeated relationship experiences with caregivers determine the adolescent's perception of the responsive availability of the attachment figure, or felt security" (Cawnthorpe, et al., 2004, p. 3; West et al., 1999). This author stresses that it is more likely for an adolescent to experience depression when they lack the security needed to maintain self-esteem, when

that is not met they can experience anger and resentment (Cawnthorpe, et al., 2004). Some have found that:

> Poor parent–child attachment due to depression in a parent, an attractor pattern (particular kinds of recognizable patterns), a temperamental mismatch (where one person's temperament is very different from another person's as to cause conflict), or another reciprocally related variable can have a strong negative impact on the onset and maintenance of depression in youth. (Stark et al., 2012, p. 2; see also Sexson, Glanville and Kaslow, 2001)

In understanding normal and abnormal behavior a sound foundation was established with the empirical support of attachment theory through a developmental psychopathology approach (Connors, 2011; see also Cassidy & Shaver, 2008). When Bowlby (1969) developed the attachment theory, his central aspect of the bond between infant and caregiver is essential for the normal development that promotes the survival of the infants (Connors, 2011). Attachment theory evaluates the importance of natural bonding that needs to occur from birth to all stages of life. During the attachment relationships, many criteria need to be established which includes the following: safety, love, security while developing a bond in very caring and trusting way between child and parent or guardian (Connors, 2011; see also Ainsworth, 1989).

Accordingly, this bond is essential for healthy growth and development of an individual’s cognitive interpretations throughout ones growth and life stages. The belief that negative things will happen while ignoring the positive aspects are outlooks that emerge and cause negative interpretations and behaviors based on harmful cognitive

types and stress therefore leading to cognitive vulnerabilities (Auerbach et al., 2013). Auerbach et al. (2013) explains through research and their own interpretations, hopelessness is believed to be an immediate ample vulnerability factor and once hopelessness develops depression follows.

## Treatment for Depression

### Cognitive Perspective

Cognitive–behavioral therapy (CBT) is a well-known and reliable treatment for adolescent depression (Kennard et al., 2009; see also Birmaher et al., 2007; Weisz, McCarty, & Valeri, 2006). However, "CBT as a psychotherapy, is composed of many treatment components, such as cognitive restructuring, behavioral activation, social skills training, and problem solving, are often included in these interventions; but the emphasis, specifics of delivery, intensity, and frequency vary" (Kennard et al., 2009; see also McCarty & Weisz, 2007; Weersing, Rozenman, & Gonzalez, 2009). Kennard et al. (2009) explains that no research was found that proves specific techniques that lead to a positive treatment outcome in depressed individuals. Very few studies address the frequency needed or number of sessions for positive treatment outcomes (Kennard et al., 2009, p. 1). "The National Institute of Mental Health revealed that research is needed to identify effective components of treatments for depressed youths to inform future adaptations that are more "potent" and more "efficient and transportable" (Kennard et al., 2009, p. 2; see also National Institute of Mental Health, 2006).

Understanding the basics of CBT helps in explaining techniques used during the process. Bieling and Grant (2007) found that CBT components such as cognitive reorganization and monitoring of one's automatic thoughts directly targets

cognitive vulnerabilities with the conclusion that this treatment aids in diminishing latent negative beliefs. Therefore, the CBT approach appears to be a promising candidate for modification of psychological vulnerability to depression by reducing the degree to which patient's access automatic negative beliefs in response to life stress (Bieling & Grant, 2007).

Kuyken, Dalgleish and Holden (2007) propose that people who suffer from depression can be assisted with CBT as it offers a refined empirically solid account of depression and research supported beneficial approach. There have been positive outcomes with CBT during therapy with persons diagnosed with depression. Kuyken et al. (2007) reports that CBT can be personalized to individual client needs with the understanding of factors contributing to constructive outcomes in therapy. Kaufman, Rohde, Seeley, Clarke and Stice (2005) found while looking at the effectiveness of CBT that the rate of automatic negative cognitions fulfilled an aspect that was addressed and provided positive outcomes; in other words CBT seemed to be effective at having a optimistic impact on negative automatic thoughts. Gillham et al. (2006) suggest in their study that cognitive-behavioral interventions with parent components such as the PRP (Penn Resiliency Program), may be operational in decreasing and
avoiding depression and anxiety in youth. Shirk, et al. (2014) found that both treatments they explored were viewed as acceptable by adolescents, were consistent with other usefulness trials of UC (usual care), and CBT and were associated with significant decreases in depressive symptoms.

Mothersill (2016) explains that "traditional CBT consists of a wide range of

methods to reduce symptoms, including cognitive restructuring techniques that emphasize the reduction of maladaptive and distorted thinking" (p. 2). Mothersill (2016) and Clark (2014) have defined cognitive restructuring as "structured, goal directed, and collaborative intervention strategies that focus on the exploration, evaluation, and substitution of the maladaptive thoughts, appraisals, and beliefs that maintain psychological disturbance" (p.3). An importance is placed on developing "realistic thinking" or "rational responses" through an investigation and adjustment of maladaptive thoughts (Mothersill, 2016, p.3).

Kuyken, et al. (2007) state that CBT can be personalized to individual client needs to positive outcomes in therapy with the understanding of factors that contributed to specific disorders such as depression. The goal of the proposed program is focused on strengthening relationship building techniques when there are attachment dysfunctions, as well as treating dysfunctional thinking patterns that lead to depression.

## Attachment Perspective

An expansion of Attachment Theory implies that humans will cognitively carry their attachment patterns into all of their relationships, including how they relate to others, their body language, facial expressions and how they react to therapy (Zilberstein, 2013). Those attachments can interfere with developing relationships and healing through the therapeutic experience. Treatment for poor attachments can be integrated into treatment for depression. Insecure attachment patterns can be recognized during treatment as self-justifying strategies that lead individuals to painful feelings or cognitions (Zilberstein, 2013; see also Liotti, 2004; Wallin, 2007). This writer believes

that most everyone will have some depressive experience, however people with poor attachments can be more susceptible to depression due to not being able to work through their emotional distress and impaired coping abilities.

## Attachment and Neurophysiological Development

When looking at metabolic aspects, insecure attachment affects corticolimbic functioning, which is involved in the modulation of emotional arousal (Connors, 2011; see also Siegel, 1999). This means that neurologically we can be more susceptible to negative emotions when those attachments are not developed from infancy. Not only during infancy but throughout life, attachment processes are important; new experiences can influence attachment organization and neuronal growth (Connors, 2011). Parish-Plass (2008) discuss that when children experience a frustrating stimulus unsuitable to the youth's juncture of development with a lack of parent support the result may be the development of higher levels of aggression and antisocial behavior in the youth.

## Neurophysiological Effects of Interaction with Animals

"Several researchers have found that the benefits that animals have on humans physiologically can include patients' experiencing a decrease in blood pressure, heart rate, and anxiety level just through interaction with a dog" (Rossetti & King, 2010; see also Barker & Dawson, 1998, p. 2). Animals also can affect the psychological level by serving as a link between the patient and therapist, in a way to build rapport (Rossetti & King, 2010; see also Barker & Dawson, 1998).

Schramm, Hediger and Lang (2015) state that "reduction of depressive symptoms in human beings is one of the most beneficial outcomes of Animal Assisted Therapy (p. 4)." There have been many studies that have shown the benefits of introducing animals

into the therapy process, including improvement in physical and psychological functioning, and social status (Levinson, 1969; see also Rossetti & King, 2010). Improving mental health, quality of life and decreasing the sense of isolation has been seen in recent meta-analysis with the use of animal-assisted therapy (AAT) (Schramm, Hediger & Lang, 2015). Decrease of depressive symptoms in humans is one of the most favorable outcomes of AAT (Schramm et al., 2015).

**Attachment and Social Development**

West & Wilkes (2004) report that adolescents are vulnerable to depression when they cannot build and maintain relationships needed to build self-esteem while feeling incompetent in relationships. When attachment needs are not met as one grows, it could lead to low self-esteem then influences the way we interpret the world around us and lead to depression. Parish-Plass (2008) explains in the following:

> That maltreated children, in reaction to their experiences with their parents, form insecure attachments and develop internal working models that are adaptive within the context of their relationships with their parents, and these models become maladaptive when employed in their relationships with others, and specifically when raising their own children (p. 4).

Kopala-Sibley, Zuroff, Leybman and Hope (2012) focus on vulnerability factors for depression in regards to dependency while looking at the role of parenting in development. They look at the role of connectedness and neediness as types of dependency while examining the level of dependency that is able to be developed between interpersonal relations, rather negative or positive reactions (Kopala-Sibley et al., 2012). As their results emerged, they found a connection between the development of

personality vulnerabilities and peer attachments to depression that are specified in multiple factors, including the relationships between parenting, peer attachments, and vulnerabilities (Kopala-Sibley et al., 2012). Kopala-Sibley et al. (2012) conclude with the thoughts that "the development of personality risk factors for depression may better allow the early identification of those at risk for depression, as well as how best to prevent the development of a vulnerable personality style" (p. 12).

Zilberstein (2013) discussed secure attachment in adolescents and adults as evident in persons who communicate about attachment in a clear and regular manner. Additionally, "avoidantly attached or dismissive grown-ups tend to devalue relationships and speak of them in a limited fashion or idealize them in a superficial way" (Zilberstein, 2013, p. 5).

> Ambivalently attached or preoccupied individuals tend to remain locked in unmet needs and talk incessantly about past experiences and longings with great emotion, while individuals who show disoriented communication and lapses in coherence in regard to topics of loss or trauma are labeled unresolved as regards to loss or trauma. (Zilberstein, 2013, p. 5)

A heathy therapeutic relationship can enhance the success of an adolescent with attachment deficits and depression. While conducting therapy a focus should be in addressing feelings, bonds, communication, emotions, trust and each individuals responsibility of the relationship that are needed in secure attachments (Zilberstein, 2013; see also Fonagy et al., 2002; Hughes, 2004; Wallin, 2007).

Investigators have reported that parent-adolescent relationships characterized by secure mutual attachments and high emotional closeness are related to positive adolescent

psychological outcomes (Constantine, 2006; see also Armsden & Greenberg, 1987). Having the parents involved in this program strengthens the success by addressing attachment discourse and building those relationships. Negative psychological outcomes are predictive of adolescents with insecure parent-adolescent attachments and less emotional closeness (Constantine, 2006; see also Cicchetti, Toth, & Lynch, 1995). Consistent with Bowlby's hypotheses, depression, anxiety, eating disorders, and personality pathology have been linked with attachment constructs (Davila & Levy, 2006).

With regard to the current proposed program development, all members of the family can add to the success of this program, including growth of positive emotions and an outlook on positive future goals. Stark et al. (2012) expresses that the attachment based family-therapy which uses components of CBT, with a focus on repairing strained parent–child attachment and promote autonomy, thus improving negative family environments. It will be imperative to structure this program around the foundation of attachment, CBT and animal attachment. Through research this author stresses that another purpose is to help youth learn effective coping skills through a newly improve attachment relationship with their parents (Stark et al., 2012).

Stark et al. (2012) and Waslick, Kandel, and Kakouros (2002) during their study found that negative mood changes from the onset of depression is found to cause an increased risk for academic decline, alcohol and drug abuse, and increase health symptoms. Stark et al. (2012) explained that parents were integrated into the treatment of adolescents to increase the effectiveness of psychosocial interventions and to develop

maximum effective treatments for diagnosed depression. When looking at better treatment plans all aspects of the adolescents' life will need to be explored to develop the most successful plan and goals for an adequate therapy process.

Stark et al. (2012) stated that "Family psychiatric history and genetics partly explain the link between parental and offspring depression, but there is also a significant environmental component" (p. 3). In addition, specific behaviors and parenting styles have been linked to the development and maintenance of depression in youth (Stark et al., 2012; see also Alloy et al., 2006). In the therapeutic relationship, "The patient–therapist bond and degree of collaboration observed in the therapeutic relationship, is often referred to as therapeutic alliance" (Levin, Henderson & Ehrenreich-May, 2012; see also Bordin, 1994, p. 1).

## Attachment and Animal-Assisted Therapy

Animal-assisted therapy (AAT) is a rising therapeutic intervention that approaches the intervention with care and healing by combining animals into the therapeutic process (Rossetti & King, 2010). The American Veterinary Medical Association (2007) defines AAT as "a goal directed intervention in which an animal meeting specific criteria is an integral part of the treatment process" (seen in Rossetti & King, 2010, p. 1). Rossetti and King (2010) insist that animal assisted therapy is designed to promote improvement in human physical, social, emotional, or cognitive functioning by professionals trained in the therapeutic process. For many years people have cared for and loved all species of animals. For example, "Levinson (1969), a pioneer in the field of pet therapy, identified the benefits of animal-human interaction in psychotherapy and

described the benefits that his pet dog, Jingles, brought to his counseling sessions with children" (Rossetti & King, 2010, p. 2). In addition, Levinson provided an abundant amount of examples in which animals improved therapy and provide proof that animals were able to be used as link to build report during therapy sessions (Rossetti & King, 2010). As history progressed the canine has been known as "man's best friend" because of their devotion and protection of their human companion.

Schramm et al. (2015) report that Animal-assisted therapy (AAT) has decreased withdrawal, increased a positive outlook on life, and decreased mental health disorders through studies. It has been learned that reduction of depressive symptoms in human subjects is one of the most beneficial outcomes of AAT (Schramm et al., 2015). Our relationships with our pets are different because our pets don't judge us or have expectations unlike our human relationships.

The International Association of Human-Animal Interaction Organizations (2014) explains how animal-assisted therapy (AAT), as a form of animal-assisted interventions, is a "goal oriented, planned and structured therapeutic intervention" that focuses on "enhancing physical, cognitive, behavioral, and/or socio-emotional functioning of the human recipient" (as seen in Schramm et al., 2015, p. 1). "An important note is that AAT is not defined as a homogeneous and independent form of intervention but serves as a method within the therapeutic process to facilitate the aspired goals" (Schramm et al., 2015, p. 2).

Parish-Plass (2008) through their studies found that Animal-Assisted Therapy (AAT) provides avenues for circumventing difficulties that have developed due to

attachment issues (in this case abuse), as well as providing additional tools for reaching the inner world of the client. The specific foundation of this therapeutic development is that Animal-Assisted Therapy is based on emotional connection and relationship – between all participants such as therapist and child with the use of the pet to narrow the gap between building a report (Parish-Plass, 2008). Many research projects throughout history and recently have found that human-animal bonds became important across many cultures (Walsh, 2009). Some professionals found that it is important to note that attachments with companion animals have been unappreciated in the field of mental health (Walsh, 2009). Those that have never experienced the devotion and compassion of a pet may have difficulty in understanding the unconditional love one has with their pet. AAT has focused on all types of animals that can be used in the therapy process, although this program will focus on the use of canines.

**Family Integration**

A study that looked at integrating cognitive and attachment theories with attachment-based family therapy (ABFT) or individual emotion-focused therapy (EFT) concluded that both conditions reported improved relationships with parents (Steinmann, Nir-Gottlieb, Shahar & Diamond, 2017). That includes building a new bond, looking at their parent in a new light, increased empathy toward parent, decrease anger, letting go of the past, and learning new coping strategies (Steinmann, Nir-Gottlieb, Shahar & Diamond, 2017). During this study, each concept added a positive effect during therapy; "ABFT clients noted the importance of their parents participating in treatment and mutual vulnerability while the EFT clients noted the importance of remembering previously

avoided memories and feelings, and getting their anger off their chest" (Steinmann et al., 2017, p. 2).

Integrating parents into the therapy process can increase a positive outcome to treatment in adolescents with depression, when that relationship is strained and there is a need for relationship improvement. Steinmann et al. (2017) concluded that their participants in the two treatment conditions reported a number of positive interpersonal treatment outcomes because their relationship with their parent had a positive change with increased bonding and gained trust. The participants in both groups concluded that they were able to become more forgiving and sympathetic toward their parents, and seeing their parents in improved light (Steinmann et al., 2017). While integrating the family into the treatment process has proven to increase relationships and decrease cognitive distortions that develop depression, this is the hope for integrating the parents into this program to build a positive bond between parent and child in hopes for future success in their emotional connections.

Venta, Shmueli-Goetz and Sharp (2014) explained that "attachment theory posits that in early development, the emotional and physical needs of a child and whether or not they are met inform the development of internal working models of the self and others" (p. 1). "Negative cognitions are also related to depression in that youth with negative cognitive styles interpret family interactions more negatively, which can in turn lead to negative interactions, and the combination leads to depression" (Stark et al., 2012; see also Alloy, Abramson, Smith, Gibb, & Neeren, 2006, p. 2). Thus, attachment styles and cognitive styles interact in developing and maintaining depression in youth.

Mothersill (2016) asked the question "If therapy could be both problem-focused and wellness-focused, might it tap a broader range of a client's resources?" This is a good question when discussing combining CBT with ATT, because it could tap into emotions that the client may never have experienced. While incorporating ATT into therapy, with the wellness of the animal is a part of this process, might provide a model for the importance of wellness for themselves to increase future success. This program assumes that with this therapy process the patient can learn to bond with others while allowing them to learn how to build relationships and attachments. Therefore, combining CBT and ATT could enhance the alliance between patient and therapist. When developing a treatment program, it increases the effectiveness of treatment when the treatment process and understanding their individualities are explored for a stronger effectiveness (Levin, Henderson & Ehrenreich-May, 2012). It is essential to become familiar with each individuals' situation, thought processes, and core beliefs in order to plan a treatment they will lead to a successful treatment.

Another aspect of this program is that it can provide a more manageable way to recognize depressive emotions, redirect negative thinking into positive thinking, and learn to feel compassion with a sense of success by being part of improving an animal's future. Participants will be able to learn emotional control, social interaction, communication, gain confidence and be empowered to see a brighter future.

## Summary

The basis of BACKtoLIFE will be developing a program with longer symptom relief of depression in adolescents for a successful future. Through research many have

found that family discourse and/or changes or traumatic events in youth with depression has a more of success when the family members such as parents are included in the treatment process (Stark et al., 2012). Many researchers found that depressed parents, who lack social skills can become less engaging and compassionate with their own children therefore doesn't meet the child's needs (Stark et al., 2012; see also Restifo & Bögels, 2009). As research was explored there were clear connections between attachments, vulnerabilities, and environmental experiences that lead to the development of depression. In addition, while exploring the success of CBT as a component it was learned that the success of therapeutic treatment was elevated.

Through strong research and exploration of treatments and theories, this program will be combining CBT with ATT in the hope that treatment will provide an extended efficacy rate so those individuals will become more successful in their future outlook and diminish those cognitive emotions that cause the depression. "Clinical implications with CBT is an evidenced-based approach to unipolar mood disorders, a case-formulation approach which permits the best evidenced-based practice and manualized approaches to be combined, and a particular emphasis on preventing relapse with recurrent depression is indicated" (Kuyken et al., 2007, p. 2). Kuyken et al. (2007) assert that the theoretical makeup of CBT relies on a descriptive review of the literature by drawing on past studies and meta-analyses.

The goals of this program are focused on strengthening relationship building techniques when there is attachment dysfunction and restoring dysfunctional thinking patterns which led to depression. The structure of CBT has many methods to reduce

symptoms that can be implemented depending on the needs of the client from addressing distorted thinking to cognitive restructuring techniques (Mothersill, 2016). Mothersill (2016) and Clark (2014) has defined cognitive restructuring as “structured, goal directed, and collaborative intervention strategy that focus on the exploration, evaluation, and substitution of the maladaptive thoughts, appraisals, and beliefs that maintain psychological disturbance” (p. 2). An importance is placed on developing “realistic thinking” or “rational responses” through an inspection and alteration of maladaptive thoughts (Mothersill, 2016, p. 2). Finally, it is essential to understand and remember that attachment theory emphasizes that in infancy, the child develops specific characteristics and self-confidence from emotional and personal touch even if those needs are not met (Venta, Shmueli-Goetz & Sharp, 2014).

BACKtoLIFE will establish a foundation that combines CBT and canine assisted therapy based on theories of attachment and cognitive behavior. The program will focus on the depressed adolescents while exploring the causes of their individual depression, emotional and relational distress. Exploring their family environment, gaining history from infancy to current time and emotional trauma that they have experienced will drive the therapy process. The hope is that this program will prove to enhance personal relationships, provide bonding experiences that will increase emotional stability through compassion, touch and love with their therapy canine. Lastly, when decreasing cognitive distortions by applying positive reinforcements a change will occur by interpreting their experiences into emotional healthy actions or behaviors.

# CHAPTER 3. PROGRAM DESIGN

The program design will establish methods for Bonding with Animals with Compassion for Knowledge to Live Indefinitely For Excellence, BACKtoLIFE. The idea behind developing this program is extending treatment duration for depression among adolescence while allowing them to experience healthy bonds and attachments. During this program they will have the opportunity to build relationships with everyone (therapist, animal, clinical staff, family and shelter employees) involved. The theoretical approach involves cognitive behavior and pet therapy. Cognitive behavior is the foundation for those experiences we are introduced to in our environment that causes our behavior, emotions or feelings. Kuyken, et al. (2007) stated that "the cognitive model of depression that contextualizes CBT exemplifies the diathesis-stress approach to psychopathology" (p. 2). The authors explain "that there are three key components: (1) the nature of the diathesis for depression (that is, what makes individuals vulnerable to the development of depression), (2) the cognitive response to stress in such depression-vulnerable individuals, and (3) the patterns of cognitive interlock that subsequently ensue" (Kuyken et al., 2007, p. 3). Evidence was obtained through the two intervention studies and confirmed that structured contacts with animals can yield beneficial outcomes which includes a range of animal species (Amiot & Bastian, 2015, p. 9). "The current zeitgeist tends to assume that animals have a positive impact on human well-being, with more empirical evidence generally confirming rather than disconfirming this positive association" (Amiot & Bastian, 2015; Herzog, 2011, p. 21). Amiot and Bastian (2015) explains that positive association was uncovered with a number of indicators of health

and well-being while with a variety of measures including self-reports and physiological measures in their research.

The Attachment theoretical approach addresses those areas in a person's life which causes them to develop symptoms that emerge into depressive disorders by unhealthy relationships or lack of attachments during infancy or childhood. Psychological researchers have tied positive attachment to be a predictor of the well-being of mental health (Venta, Shmueli-Goetz & Sharp, 2014). Venta et al. (2014) explains how "adolescence represents an important transitional period and is associated with considerable changes in psychosocial functioning and centrally in attachment relationships" (p. 1). This program allows the adolescent to experience the ability to build attachments/bonds with animals, become the caretaker of the animal while learning responsibility and recognize depressive emotions while gaining skills to manage those emotions. The development of BACKtoLIFE is to allow and support assessment measures to ensure success and manage outcome measures. The program design can set up for future success in treatment of depression among adolescents and establish healthy relationships.

## Needs Assessment

The county that this dissertation is assessing needs of the proposed program consist of a total population more than 70,000 with 2.4% females and 2.54% males between the ages of 5 and 17 as of 2015 (U.S. Census Bureau, 2015). The research that has been found regarding adolescent outpatient programs in this county has found zero addressing mental health. For example, there are juvenile faculties for those that have

legal issues, three clubs, two inpatient facilities, three drug and rehab facilities and then just basic medical hospitals or clinics available for short term care. There are many psychological centers that do therapy and psychological assessments, although none have any outpatient programs that address the adolescent population for depression treatments. The Texas Department of State Health Services reported serving 12% of Medicaid and indigent children in the year 2013 for depression for the entire state (Department of State Health Services, 2017). The DSHS (2017) reported that individuals without mental health live longer at a rate of 25 years than those with mental health issues. A child with serious emotional disturbance is defined as someone 9-17 years old who has a diagnosable mental disorder that severely disrupts his or her ability to function socially (DSHS, 2017). In the state of Texas alone it was reported that approximately 262, 000 (11.2%) adolescents ages 12-17 per year in 2013-2014 had at least one Major Depressive Episode:

"In Texas, about 75,000 adolescents aged 12–17 with MDE (35.3% of all adolescents with MDE) per year from 2010 to 2014 received treatment for their depression within the year prior to being surveyed" (SAMHSA, 2015, p. 1).

There have been several organizations that use pets as part of therapy. Paws across Texas has the PAT program "that promotes a trusting and bonding relationship in a voluntary and nonthreatening environment for psychological and physical responses and interactions" (p. 1). Baylor University and many other hospitals allow for therapy dogs to come and visit patients that have been in the hospital for many reasons. However, during the current research for existing programs in the surrounding area there are minimal programs found that involves animal therapy and no programs in the current

county where the program will be developed. Schramm et al. (2015) and The International Association of Human-Animal Interaction Organizations (2014) explain that animal-assisted therapy, is "a goal oriented, planned and structured therapeutic intervention that focuses on enhancing physical, cognitive, behavioral, and/or socio-emotional functioning of the human recipient" (p. 2). In addition, CBT as an intervention in treatment of adolescent depression is widely available in this area. However, there are no programs offering the combined therapies, AAT and CBT. The proposed program incorporates AAT with CBT, both interventions that have been shown to be effective in the treatment of symptoms of depression.

Due to the lack of programs in the writer's surrounding area involving animal therapy and CBT for treatment of depression in adolescents, it would be beneficial to develop such a program for this population that allows children to interact with animals for calming effects, redirect their own feelings to care for another, and develop bonds that reduce their own fears, agitation and worry while exploring and changing the thought processes that support depressive symptoms.

Another focus of this program is to reach all adolescents regardless of their economic or healthcare status, race and culture. This program will work with each individual separately in order to supply them the opportunity to go through the program. This will be laid out further in this chapter so all financial criterion can be explored for each individual participant.

There has been a rise over decades with abandoned and lost pets. This program will contribute in rescuing pets while incorporating them into therapy with the goal to

prepare them for a forever loving home. This program will establish a relationship with a local shelter with legal and binding agreements of adoption, contributing to fundraising and volunteering in the care of the animals. In addition, each pet will be required to have all vaccinations, be on heartworm prevention and be spayed or neutered before being transferred to BACKtoLIFE. Many authors have expressed that regarding mental health, integrating animals into the therapy process will narrow the gap and increase the possibly that a report will build at a faster pace (Schramm et al., 2015; see also Wohlfarth, Mutschler, Beetz, Kreuser, & Korsten-Reck, 2013). Schramm et al. (2015) explains that therapy pets establish an opportunity to open conversations while lessening the persons anxiety because it involves the patient while providing roles changes. Animal therapy provides the person with an opportunity as a caregiver of a pet while receiving calming physical contact in a natural setting in a therapy setting (Schramm et al., 2015). The goal of the program is to rescue abandoned pets and give them an opportunity for a future while providing depressed adolescents the experience of an unexplained emotional connection that develops through compassion, bonding and love.

## Program Measures

The assessment measures that have been chosen will measure the success of the program while addressing depression, anxiety, attachments and family relationships. Those assessment measures will be the BDI, RADS-2, STAI, FAM III and IPPA-R. All of the assessments will be given before starting the program, at six weeks and after the last session of the 12 weeks except for the FAM III, it will be only given twice to each family member before and after. The effectiveness of the program will be measured by

the following scales: The Beck Depression Inventory (BDI) (APA, 2017); The Reynolds Adolescent Depression Scale-2 (RADS-2); The State-Trait Anxiety Inventory (STAI); The Family Assessment Measure (FAM III) and The Inventory of Parent and Peer Attachment–Revised (IPPA-R). All forms can be bought and administered to each participant easily and within 5 -15 minutes except the FAM III. The FAM III has several forms which can take 30-40 minutes to complete.

The BDI can be purchased in a kit for $132.95, while additional testing forms are $58.85 for 25 forms. The RADS-2 can be ordered online for $179.00, including the Manuel, testing forms and instructions for administering, scoring, and interpreting results. The STAI can be printed off from the Internet for free, but if you need or want an internet report it will run 15.00 per report; otherwise, it can be scored and interpreted by hand. The FAM III can be initially purchased as a kit for 93.00, which includes the manual (84.00), color plots (15-3.00), self-rating scales (25-2.00), dyadic relationship scale (25-2.00) and general scale (30-2.00). The IPPA-R can be downloaded for free and printed.

## Objective Measures

The Beck Depression Inventory (BDI) measures characteristic attitudes and symptoms of depression in a 21-item self-report (APA, 2017; Beck et al., 1961). The BDI takes approximately ten minutes to take, although clients require a fifth to sixth grade reading level to adequately understand the questions (APA, 2017; Groth-Marnat, 1990). “Internal consistency for the BDI ranges from .73 to .92 with a mean of .86.” (APA, 2017; see also Beck, Steer, & Garbin, 1988, p. 1). “Similar reliabilities have been found for the 13-item short form” (APA, 2017; see also Groth-Marnat, 1990, p. 1). “The BDI

demonstrates high internal consistency, with alpha coefficients of .86 and .81 for psychiatric and non-psychiatric populations respectively" (APA, 2017; see also Beck et al., 1988, p. 1).

The Reynolds Adolescent Depression Scale-2 (RADS-2) is used as a screening tool for significant depressive symptoms in various settings for all adolescents (SIGMA, 2017). "The RADS-2 is a brief, 30-item self-report measure that includes subscales which evaluate the current level of an adolescent's depressive symptomatology along four basic dimensions of depression: Dysphoric Mood, Anhedonia/Negative Affect, Negative Self-Evaluation, and Somatic Complaints" (SIGMA, 2017, p. 1). The four subscales rely on the level of depression and item content during interpretation. (SIGMA, 2017).

Date such as internal consistency, test-retest, and SEMs are presented for the scale that measures the total overall of depression and the four subscales in the technical manual to present a reliability factor (SIGMA, 2017). "Validity of the RADS-2 was examined from a number of perspectives: content validity, criterion-related validity, construct validity (convergent, discriminant, and factorial), and clinical validity" (SIGMA, 2017, p. 1). In order to provide the severity of depressive symptoms ranging from normal, mild, moderate, or severe the RADS-2 provides a standard (T) scores and associated clinical cutoff score. (SIGMA, 2017).

The State-Trait Anxiety Inventory (STAI) is a commonly used measure of trait (how they feel overall) and state (how they have felt the last week) anxiety, while being used in clinical settings to diagnose anxiety and rule out depressive syndromes (APA, 2017; see also Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983). APA (2017)

explains how the Y form, has 20 items for assessing trait anxiety and 20 for state anxiety. State anxiety items has examples such as “I am tense; I am worried” and “I feel calm; I feel secure.” Trait anxiety items has examples such as “I worry too much over something that really doesn’t matter” and “I am content; I am a steady person.” The reader has to have at least a sixth grade reading level and all items are rated on a 4-point scale 0 to 4 never, sometimes, often, or almost always, higher scores indicate greater anxiety (APA, 2017).

“Internal consistency coefficients for the scale have ranged from .86 to .95; test-retest reliability coefficients have ranged from .65 to .75 over a 2-month interval” (APA, 2017; see also Spielberger et al., 1983, p. 1). “Test-retest coefficients for this measure in the present study ranged from .69 to .89” (APA, 2017; see also Spielberger et al., 1983, p. 1). Considerable evidence confirms to the build and validity of the scale (APA, 2017; see also Spielberger, 1989). This assessment has been reported to being a predictor of distress in a patient but may change as their support systems change such as health or other characteristics (APA, 2017; see also Elliott, Shewchuk, & Richards, 2001; Shewchuk, Richards & Elliott, 1998).

“The Family Assessment Measure III (FAM III) is a self-report instrument that provides quantitative indices of family strengths and weaknesses and is based on a Process Model of Family Functioning that integrates different approaches to family therapy and research” (Skinner, Steinhauer & Santa-Barbara, 2004, p. 1). Skinner et al. (2004) explains “that the FAM III measures seven different concepts, which are Task Accomplishment, Role Performance, Communication, Affective Expression,

Involvement, Control and Values and Norms" (p. 1). "The FAM consists of three forms/types; the general Scale, which focuses on the family as system, the Dyadic Relationships Scale, which examines relationships between specific pairs and the Self-Rating Scale, which taps individual's perceptions of his/her functioning in the family" (Skinner et al., 2004). The assessment has several forms and may take 30-40 minutes to administer depending upon how many forms you utilize (Skinner et al., 2004).

In one study the assessment uses the Process Model of Family Functioning which is known as Task Accomplishment (developmental and crisis tasks) and was developed to measure the achievement of the family (Skinner et al., 2004). The family successfully or unsuccessfully achieves it objects which are essential to them as a whole through the process of Task Accomplishment (Skinner et al., 2004). "The Process Model of Family Functioning emphasizes family dynamics that are relevant to family health-pathology" (Skinner et al., 2004, p. 1). Skinner et al. (2004) provides information that the FAM III can be administered in paper-and-pencil form using Multi-Health Systems QuickScore Forms. "It is recommended that every family member (age 10 or older) should have up to three FAM QuickScore Forms: (1) General Scale (Green), (2) Dyadic Relationship Scale (blue), (3) Self-Rating Scale (yellow), with corresponding colored answer sheets" (Skinner et al., 2004, p. 1).

"The Inventory of Parent and Peer Attachment–Revised (IPPA□R) is an index of the quality of communication, feelings of trust, and degree of alienation that adolescents and young adults perceive in their parental and peer relationships" (Andretta, McKay, Harvey, & Perry, 2017, p. 1). The first 25 questions asks about the adolescents'

relationships with their mother, while each of the statements asks about their feelings toward their mother, guardian or the person that has had the most influence (Andretta et al., 2017). The next 25 questions, asks them about their relationship with their male parent, while the last 24 questions asks them about their relationship with their close friends (Andretta et al., 2017). “The IPPA was developed in order to assess adolescents' perceptions of the positive and negative affective/cognitive dimension of relationships with parents and close friends -- particularly how well these figures serve as sources of psychological security” (Andretta et al., 2017).

## Program Candidate Selection

The population for BACKtoLIFE will be adolescent girl’s ages 13 to 17-years-old. As stated, this program was designed for adolescent girls with a diagnosis of depression with possible attachment issues. Referrals could come from local psychologists, schools, state/government agencies or churches. When the program is established all information and requirements will be emailed to all surrounding referral agencies. This age group was selected as it is consistent with adolescent development through statistical data, assessment measures, and indicated in supporting research studies. The BACKtoLIFE design is directed towards extending the efficacy of depression treatment, strengthening family attachments and promoting emotional wellness and resiliency. The participants will need to be diagnosed with depression and currently experiencing psychological distress that can be addressed during the program. Participation will include any female, from any race, with multicultural aspects of consideration for participants. It is important to recognize cultural implications.

## Program Screening

Each participant in BACKtoLIFE will initially participate in a two-hour clinical assessment of gathering information (e.g., psychosocial history of medical, medical history, family mental health history, social interaction and academic history, possible abuse, and supporting information) and administering of the assessments. The two-hour clinical interview and assessments will be conducted during a scheduled appointment and performed by a licensed psychologist or licensed professional counselor. The administration of the objective measurements (e.g., BDI, RADS-2, IPPA-R and STAI) will be part of the clinical interview. The BDI and RADS-2 will be given first in the administration of the measures to determine if there is depression and the level of depression. Due to the possibility of anxious distress with a diagnosis of depression, the examiner will assess that criteria to rule it out. The STAI will be given second to determine if there is anxiety and the level of anxiety. The IPPA-R will be given third to understand their attachment relationships. Upon completion of the screening process, the female youth and her family will be presented with the program information. If they are interested then all other information will be presented. A later appointment date will be set for the administration of the FAM III. They will have the ability to ask all questions of concerns about their participation of the program.

Once that administration is completed a start date, time and schedule will be developed with patient and family. The start date of the individual will begin at the shelter as an introduction to the process, introduction to their assigned canine and shelter staff. Their assigned pet will be signed out and moved to the psychological facility where it will be kenneled and cared for through the process. Their individual therapy session

will be scheduled at the therapist office and include their assigned pet. They will be instructed on the care and husbandry of their therapy pet, the process of adoption with clear understanding that if that dog can be adopted another pet will be assigned. There will be a therapy dog bulletin board at the shelter in the case of possible adoption. In addition, the psychology office will have their own website and conduct adoption options through the facility. They will be assigned to a group and family sessions which will be set up for biweekly sessions at the therapist office. In other words, they will have a group session one week then a family session the opposite week. They will be required to volunteer one day a week at the shelter and schedule that with the staff for the next 12 weeks.

## Admission Criteria

The admission criteria include female adolescents ages 13 to 17 that have completed the initial clinical interview and assessments measures for depression and anxiety, participation agreement from participant and her family, and all agreed and signed consensual and confidential documents. The youth will need to demonstrate appropriate understanding of their part and commitment as consideration for admission. If the therapist does feel that the adolescent is a good fit for BACKtoLIFE, a meeting with the other clinical and shelter staff will be conducted. The next goal is for the therapist to prepare all participants for the introduction of the program, while preparing the shelter staff of their role in the program. The participant will be re-assessed at six weeks and at the end of the 12 weeks regarding depression and anxiety measures. For the BACKtoLIFE to be effective, the consistency of each participant's attendance is crucial. The BACKtoLIFE program is based on evidence-based research protocol to determine

the effectiveness of participants through consistency. The participants and families will be required to agree to their participation in all scheduled sessions. Withdrawal from the BACKtoLIFE will be provided due to medical illnesses, the discretion of the therapist and unexpected life events. These participants could be able to re-enter the BACKtoLIFE program at any future time with the discretion of the therapist.

## Exclusion Criteria

The exclusions from the BACKtoLIFE will be based on if a participant has any medical concerns, lack of transportation, and a fear of animals which could cause potential harm that would interfere and compromise the participants' success in therapy. There has to be a family involvement and their agreement to all aspects of the program process. All participants have to provide their own transportation to and from the psychological office and shelter. All forms and confidentiality agreement will have to be signed, discussed and agreed upon. The participants will be required to volunteer once a week at the shelter, attend all individual, group and family sessions. If in any case the adolescent has no family it will be up to the discretion of the therapist to allow them into the program and modifications will be made to best assist that participant.

## Program Frequency, Duration, & Group Design

### Program Frequency & Duration

The BACKtoLIFE program will have a timeline of twice per year. The program will begin in the first of April until the end of May, then the first of August until the end of October. This program is rigorous and the participant and their family will need to be committed to see it through before deciding to begin. The twelve weeks will be dedicated to the participants own emotional state while being able to learn and experience lifelong

strategies regarding their own attachments, bonds and self-efficacy.

## Group Design and Program Curriculum

### Individual Therapy

The individual sessions will be weekly and with their therapy pet. The pet will bridge the gap for the adolescent and therapist by implementing trust in the process. This process will be guided by the adolescent, and they will have several options for where the session takes place. The therapist will go where the client is for topics and discussion with a client centered perspective. They will decide on their goals and homework. During sessions they will be educated on depression or any other disorders that may arise in discussion (Appendix K).

### Family Support Group

BACKtoLIFE will strive to involve families with private family therapy sessions in the psychological facility. This will give the participants an opportunity to address their own needs and struggles with the family and begin resolving any conflicts. Family involvement for adolescents will be essential in building those attachments or relationships that have been affected or never established. These sessions will be every two weeks, the opposite week of their group therapy sessions. The family support groups will be offered the ability to continue their sessions as well when the program is completed (Appendix F).

### Peer Support Group

The topics for the peer support group designed will be conducted in open forum and team building experiences. The peer support group is for the adolescents that have

begun the BACKtoLIFE program. Additionally, the peer support group will be for those youth that have gained parental consent to attend the psychoeducational group. The group will allow for the adolescent to continue discussing on-going concerns, emotions and issues that have been a factor in them developing depression. The group members will continue in open discussion of their struggles, goals for the program and goals for their future. They will experience team building exercises while building relationships. It will be centered on building relationships and supporting each other’s goals. The sessions will be outside unless the weather doesn’t permit it and will include their assigned canine. The therapist will facilitate the group to ensure safety and appropriateness of topics and uphold confidentiality. Everyone involved will sign a confidentiality contract to ensure no discussions are expressed outside of the group session (Appendix G).

Table 2. Program Treatment Plan

| **Session** | **Goals & Objectives** | **Activity** | **Outcomes** |
|---|---|---|---|
| **One** | **Goals:** To help Participant acclimate to group **Objectives:** For all participants to feel comfortable in group setting | **Icebreaker:** Group introductions and establishing ground rules for the group. Importance of rules. | Discussion of how the participants feel about the group and its goals. |
| **Two** | **Goals:** What does it mean to identify as a female adolescent? **Objectives:** For Participants to identify as a group | Review homework assignment: Allow each participant to read their short description. Team building exercises | Self-awareness feel comfortable about discussing emotions and feelings surrounding one’s identification. |
| **Three** | **Goals:** Setting Goals and identifying depression **Objectives:** For participants to learn how to work as a group | Share their goals with the group. Discussion of thoughts, feelings, and emotions | Becoming comfortable in a group setting while building self-esteem and confidence |

| | | | |
|---|---|---|---|
| | | regarding depression. Team Building | |
| **Four** | **Goals:** Discuss and Identify Stress and social difficulties and bullying.<br>**Objectives:** For participants to identify with group members | Animal Identification and Team building exercise | Trust and Recognition |
| **Five** | **Goals:** Developing open communication skills<br>**Objectives:** How to speak up for yourself | Engage in role-plays in demonstrating effective communication | Build social skills |
| **Six** | **Goals:** Building relationships<br>**Objectives:** Supplying Resources for adolescents/Conclude | Open discussion about what they have learned from others in the group. | Decreasing depressive symptoms and building self-esteem and social skills |

**BACKtoLIFE Group Curriculum**

BACKtoLIFE will provide resources to guide the understanding needed to manage their depression, anxiety or attachment issues as they move forward from the program. This program will offer opportunities for future involvement in animal welfare and support through other organizations if they develop an interest in continuing to help animals. This could include future jobs in training, boarding of animals and veterinarian opportunities. They can continue to volunteer at other facilities that need help or go off and accomplish their own dreams. This method can open doors they never knew existed and assist in developing future dreams and goals.

## Physical Setting

The specific location for the BACKtoLIFE will be at the Psychological office of the therapist within the local community. The physical setting for the BACKtoLIFE program consist of individual offices for private therapy sessions, an outdoor private facility, and a barn that consist of kennel runs to house the canines. The barn will have 10 runs that are 8ft x 10ft with an exit to an outside yard. A conference room for the family and group sessions when not being held outside. The discretion of areas to hold the sessions will be set up by the therapist.  The conference room can hold up to 12 persons and will contain informational support for families. The office space will have six to eight offices for the clinical staff, outdoor private areas, storage, play room, small kitchen and available restrooms. The materials necessary for the facility and program are a printer/copier for handouts and other needs, a dry erase board, computer, overhead projector to assess media related to the psychoeducational modules if warranted and a variety of office supplies as needed.

## Dismissal Policy

The grounds for dismissal are discussed as part of the clinical assessment and the initial group and family sessions. The rules for dismissal include disruptive behavior, lack of attendance, electronic devices, tardy, respect, limits of confidentiality and unexcused absence. The participants must follow and adhere to the rules. A dismissal policy form will be signed by the participant (see Appendix D for form).  The rules of dismissal will be a discussed with parents and/or guardians and addressed age appropriately with each participant. For excused absences, participants will be able to make up missed scheduled sessions.

Participants that do not follow group confidentiality may be asked to leave the program. Clinical staff will inform and clarify that any disruptive behavior, verbal threats, or physical violence will not be a tolerated within the group sessions. If a participant misses more than two agreed volunteer schedules or sessions without prior notice, the participant will be removed from the program. The participant will be offered a future date to re-attend the program or choose traditional therapy in an office setting. No participant will be allowed to leave early from individual, group or family sessions unless for medical reasons. Included in this process, it will be clear that if there is any potential circumstance that may project harm onto the other participants, there will be exclusion from the group sessions for the participant. The participant can only return by the therapist approval. At any time, modifications to the BACKtoLIFE program will be considered by the therapist if she/he deems it necessary regarding all aspects of the program.

This program will have a zero tolerance policy regarding any observed, reported, or suspected instances of abuse or neglect that will be followed. Any abuse (e.g., physical, sexual, verbal or/and mental) from participants or family will not be tolerated. The therapist and/or clinical staff will be upheld to make a report to the Department of Child and Family Services. There will be no tolerance of any adolescent or parents/guardians under the influence of drugs/alcohol, if found to be true they will be asked to leave the premises with possible termination of the program and/or necessary authorities will be called. If this is found to be true there will be a referral made available to resources in the community to provide drug and alcohol counseling. With treatment they could be readmitted at a later date. The dismissal policy will be upheld at the shelter

they volunteer at as well and the therapist will consult weekly with the shelter staff on their performance. The goal of BACKtoLIFE will be to establish a safe and welcoming environment for all participants at the shelter and psychological office. The clinical and shelter staff will be educated on all possible exclusion processes and will have to report to the therapist. The therapist will make the decision to implement the dismissal. In the termination process the participant will be offered with the ability to continue traditional therapy sessions if they feel it necessary and/or offered an open door invitation to schedule a session whenever they feel the need moving forward.

## Program Director and Clinical Staff Qualifications

The administration of BACKtoLIFE will be overseen by a program director, and a licensed doctoral level psychologist. The BACKtoLIFE Director will oversee the clinical staff and their duties deemed necessary for the program. The license psychologist will facilitate the initial clinical assessment, re-assessments, and each group and family sessions for the duration of the each scheduled implementations of BACKtoLIFE. The clinical staff may consist of several master's level licensed therapist, and other doctoral licensed psychologist, kennel assistant and several administrative staff.

The overall training for the BACKtoLIFE process will be to ensure the staffs' understanding of their roll and guidance throughout the process. The BACKtoLIFE program will be implemented solely by the licensed psychologist while the staff will assist her/him as needed from session to session. The clinical staff will ensure all documentation preparation, introduction, storage, and confidentiality requirements. All staff members will report to the licensed psychologist when deemed necessary regarding participant's attendance, behavior and general needs assessment. The overall training is

crucial for the clinical staff to maintain fidelity to the implementation of BACKtoLIFE. In maintaining ethics to the program, the clinical staff will demonstrate the general principals set forth by the ethical considerations of APA (2017) by implementing the integrity, fidelity and responsibility, beneficence and non-maleficence, justice, and respect for people's rights and dignity. They will conduct themselves in regard through a flexible, non-judgmental stance.

At any time with the discretion of the therapist, a master's level licensed therapist may co-facilitate the group sessions. The BACKtoLIFE program will be conducted in the spring and fall. The licensed psychologist will provide two or more hours of continuing educational training that is pertinent in working with the adolescent population. The purpose is to maintain the implementation of best practices for adolescent population with depression. Clinical staff must have the knowledge of the CBT approach and animal assisted therapy. The clinical staff will understand the ability to apply and incorporate empathy, and unconditional positive regard.

## Program Support

Referrals and support from other licensed psychologists, churches, academic facilities, doctors, crisis centers, parents, and surrounding animal rescue groups will be sought out for the BACKtoLIFE to be effective in a community. The marketing will be conducted through presentations and advertising by the BACKtoLIFE staffers to provide program details and education regarding the goals and foundation of BACKtoLIFE. The presentations will be conducted at the site of the audience being addressed (e.g. schools, hospitals, and other local agencies). The use of program fliers are to inform all therapists and physicians about the BACKtoLIFE, while bringing awareness of depression in the

youth population. Additionally, program flyers will be available for the surrounding community for parents, families, friends, and youth and adolescent clubs or organizations. Open house adoptions will be scheduled to promote the BACKtoLIFE program for the adoption of the pets used throughout the program. The participant will be encouraged to assist in finding the pets a good home or have the option to adopt their therapy pet. In addition, adoption regulations will be met by ensuring a safe environment, pet husbandry education and proper vet visits for vaccinations and heartworm pretention yearly. The use of flyers will be to bring awareness to the program, adoption of local homeless pets, and to provide awareness for the growth in the treatment of depression. As BACKtoLIFE grows, the presentations will be on going as needed. The goal is to present BACKtoLIFE for the possibilities mentioned above in gaining referrals to establish initial participants.

## Ethical Considerations

To ensure that this program BACKtoLIFE is successful and no harm comes to the participants it is essential to identify any potential ethical considerations. Adolescents that enter into therapy (individual, family and group) may be at potential risk for ethical concerns. There are no study participants or data collection for data analysis due to this dissertation being a program design. One of the most essential ethical concern is confidentiality, which will be discussed several times with the participants and how confidentiality has limitations due to being in a multiple therapeutic settings. The purpose is to stress to all participants that confidentiality is important and crucial to follow. All participants will sign a consent form detailing confidentiality and must sign before their first group, family and individual sessions. The BACKtoLIFE program will involve one

consent form that includes access to family, individual, and group therapy (a copy of the informed consents are in Appendix C) for the adolescent and parent as part of the clinical assessment. The informed consent will provide information regarding mandatory reporting of abuse, duty to warn, confidentiality for participants and the need to breach confidentiality by clinical staff. This program will implement their own code of ethical conduct rules for maintaining health and ethical treatment of the therapy pets (see Appendix L).

Under Texas State Law it provides guidance for the age (18) at which a person may consent to psychotherapy; therefore, it is the policy of this program to provide parents or legal guardians all of the information below, and obtain their consent during the initial process. It is essential during this program that they are informed and in agreeance of the success the youth can potentially gain from participating in the individual, family and group therapy sessions. The Texas State Law (Sec. 32.004) has exceptions, first a child 16 years old or older that is living away from their parents and financially supporting self can consent to therapy, and second an emancipated child may consent to therapy for substance abuse, suicide prevention, and sexual, physical, or emotional abuse.

The informed consent ethical considerations are instructed by APA (2017) under the ethical code of conduct and reads as follows:

> APA (2017) 3.10 Informed Consent (a) When psychologists conduct research or provide assessment, therapy, counseling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is

> reasonably understandable to that person or persons except when conducting such activities without consent is mandated by law or governmental regulation or as otherwise provided in this Ethics Code. (See also Standards 10.01, Informed Consent to Therapy) (b) For persons who are legally incapable of giving informed consent, psychologists nevertheless (1) provide an appropriate explanation, (2) seek the individual's assent, (3) consider such persons' preferences and best interests, and (4) obtain appropriate permission from a legally authorized person, if such substitute consent is permitted or required by law. When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare. (c) When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding. (d) Psychologists appropriately document written or oral consent, permission, and assent. (See also Standards 10.01, Informed Consent to Therapy)

Included in the informed consent process are ethical considerations regarding specifically to therapy. The APA (2017) ethical code specifies that:

> APA (2017) 10.01 Informed Consent to Therapy (a) When obtaining informed consent to therapy as required in Standard 3.10, Informed Consent, psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the

client/patient to ask questions and receive answers. (See also Standards 4.02, Discussing the Limits of Confidentiality) (b) When obtaining informed consent for treatment for which generally recognized techniques and procedures have not been established, psychologists inform their clients/patients of the developing nature of the treatment, the potential risks involved, alternative treatments that may be available, and the voluntary nature of their participation. (See also Standards 2.01e, Boundaries of Competence, and 3.10, Informed Consent.) (c) When the therapist is a trainee and the legal responsibility for the treatment provided resides with the supervisor, the client/patient, as part of the informed consent procedure, is informed that the therapist is in training and is being supervised and is given the name of the supervisor.

In discussing the program with the family, a specification of the role of each participant will be explained and clarification is laid out in the consent form. In regards to family therapy the ethical considerations are set forth by APA (2017) as follows:

> APA (2017) 10.02 Therapy Involving Couples or Families (a) When psychologists agree to provide services to several persons who have a relationship (such as spouses, significant others, or parents and children), they take reasonable steps to clarify at the outset (1) which of the individuals are clients/patients and (2) the relationship the psychologist will have with each person. This clarification includes the psychologist's role and the probable uses of the services provided or the information obtained. (See also Standard 4.02, Discussing the Limits of Confidentiality.) (b) If it becomes apparent that psychologists may be called on to perform potentially conflicting roles (such as

family therapist and then witness for one party in divorce proceedings), psychologists take reasonable steps to clarify and modify, or withdraw from, roles appropriately. (See also Standard 3.05c, Multiple Relationships.)

The final therapy process consists of group therapy and the expectations of group therapy will be discussed and presented according to the APA (2017) as follows:

> 10.03 Group Therapy, When psychologists provide services to several persons in a group setting, they describe at the outset the roles and responsibilities of all parties and the limits of confidentiality.

If in any case that they choose not to give consent for any part of the program they will have the opportunity to seek other therapy programs and be provided with referrals for other options of treatment. There will be a clear explanation of the legality of consent to move forward regarding any mental health treatments.

Individual, family and group therapy, all have benefits and risks. The risk at times include experiencing anxiety, frustration, and painful feelings, such as sadness, helplessness, loneliness, and guilt. Many times emotional distress has been submerged for such a long time it is difficult to express those feelings or relive them so they see it as a risk to themselves. There will need to be a clear understanding that therapy requires that the participant discusses unpleasant aspects of her life in which psychoeducation will be needed. Explanation of how therapy can produce benefits for those that implement the techniques, tools, and resources learned in the sessions. Discussing that therapy often leads to a significant decline in feelings of distress, greater personal awareness, improved satisfaction in interpersonal relationships, increased skills for managing anxiety and resolutions to specific problems. This therapy process requires a

very active effort on the participant's part with commitment to follow through with the care of their assigned therapy pet. In order to be most successful, the participant will have to work outside of sessions on those goals they set in therapy.

Maintaining and setting the limitations of confidentiality is an ethical standard set forth in the APA (2017) code of ethical standards and reads as follows:

> APA (2017) 4.01 Maintaining Confidentiality, Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship. APA (2017) 4.02 Discussing the Limits of Confidentiality (a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (See also Standard 3.10, Informed Consent.) (b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant. (c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.

Finally another ethical standard that is essential in this program is the Duty to Warn, to do no harm will apply for the participants and animals used in the process. The APA (2017) ethical standard reads as follows:

> 3.04 Avoiding Harm (a) Psychologists take reasonable steps to avoid harming their clients/patients, students, supervisees, research participants, organizational clients, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable. (b) Psychologists do not participate in, facilitate, assist, or otherwise engage in torture, defined as any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person, or in any other cruel, inhuman, or degrading behavior that violates 3.04 (a).

## Crisis Intervention

For the safety of each participant, they will be required to complete a No-Harm contract (See Appendix E). A copy of the No-Harm contract will remain in the facility. The second level of safety is to build a network alliance to assist any adolescent that voice suicide or experiencing a crisis during the program. On-going crisis intervention will be offered to all participants regardless if he/she is a participant of the BACKtoLIFE or not. The clinical staff will be the first line of intervention to assist the adolescent. The clinical staff will conduct a suicide risk assessment as follows:

Key components of a suicide risk assessment

1. Clinical judgment
2. Assess risk factors
3. Assess protective factors
4. Document
5. Suicide Inquiry: thoughts/plan /intent/access to means

A major goal of crisis intervention is to allow for a safe place and for the adolescent to feel safe to express her issues. The next goal is for the therapist to ask nonjudgmental questions so as not to increase frustrations. The following goal is to help the adolescent at that moment, provide resources, and discuss the importance of building resilience to deal with difficult situations. The therapist will assess for an active suicide plan and access to lethal means. If the adolescent does not have an active plan and access to lethal means, she will be directed to follow a No-Harm contract. The therapist will follow-up with the adolescent through sessions in the program. In addition, a list of resources will be provided to the participant. The third level of safety will be for the therapist to notify psychiatric services or authorities if needed to assist the adolescent.

BACKtoLIFE strives to ensure therapeutic care and respect towards all participants, human and animal. Although animal assisted therapy has increased over the years, there has been no code of ethics developed regarding this practice in the psychology field. This program will greatly emphasize the care and wellbeing of the animals chosen to enter into the program. BACKtoLIFE will provide its own ethical standards that reads as the following:

> 001 BACKtoLIFE Standard, Avoiding Harm (a) Psychologist, clinical staff, participants and/or anyone in contact or subject to interact with a therapy animals may do no harm of any, physical or mental to the animal. (b) Psychologist, clinical staff or anyone working at the psychological facility shall have knowledge and training in husbandry, proper care techniques, and observational skills regarding recognizing health issues and if those arise relay concerns to the psychology staff immediately. (c) Animal Assisted therapist and staff will comply to all state laws

regarding the care of animals and husbandry with training of all staff members, once a year or as entering into employment at the facility (§ 42.092. Cruelty to Nonlivestock Animals) (see in Appendix I). (d) Animal-assisted therapists must be aware of their responsibilities and duties, and adhere to the regulations set forth in this document. (e) Animal-assisted therapists must document sessions and summarize them professionally for when documentation and updates are necessary. The reporting process will be conducted in such a way as to maintain patient-therapist confidentiality, with use of personal discretion and judgment. (f) Animal-assisted therapists must maintain strong professional ties (through training, consultation and discussion) with other professionals in the fields of mental health, welfare, education and veterinary services, appropriate to the population they work with.

The objective of this program is to strengthen the treatment of depression in the adolescent population while incorporating CBT and AAT. It is important to supply a safe environment for the therapy pets that are free of hunger, thirst, injury, distress or discomfort. The objective is to allow them the opportunity to bring comfort and loyalty to the participants while experiencing love and compassion themselves. This process is a natural experience that emerges through unconditional love, care and compassion.

## Expected Findings

The anticipated outcome for BACKtoLIFE is the overall development of a program that has the potential for lengthening the treatment for depression in adolescents and acquire specific funding. The anticipated findings for this program design are projections for significant gains in learning more about psychological depression and the

other crucial issues among adolescent populations. There is the assumption that adolescents entering to the program have sufficient levels of psychological distress and relational distress. The expectation of participating in the BACKtoLIFE is the decrease of psychological distress, strengthening relationships and decreasing suicidality by promoting resilience to maintain emotional wellness for their future success. “This duel program will maintain that there are two motivations for human–animal interaction, first is to elicit emotional advantages and second is the utility value for humankind” (Lubbe & Scholtz, 2013; see also Hettema, 2002, p. 1). The program will effectively improve communication skills, emotional connections and promote a positive goal driven lifestyle in adolescents. Future research studies will assess the effectiveness of this form of intervention.

## Summary

This chapter outlined the design of the BACKtoLIFE. BACKtoLIFE’s foundation is a basis for the Cognitive Behavioral and Animal Assisted combined Therapy. The following chapter outlines the evaluation and implementation of assessments used to measure success of treatment in the BACKtoLIFE.

# CHAPTER 4. PROGRAM DEVELOPMENT

Development of BACKtoLIFE was designed by making appropriate evaluations and implementations to provide the effectiveness of the program. The Cognitive Behavior and Animal Assistant Approach has been proven successful within separate research documentations in the adolescent population. The effectiveness of combining both theoretical frameworks with the adolescent population is yet been tested. This chapter begins with a focus on the BACKtoLIFE implementation and a description of the program and the training of the clinical staff. This chapter outlines the programs characteristics, estimates a budget, participants cost and locations indicated for the program. Additionally, this chapter will discuss how to measure the effectiveness of the BACKtoLIFE through an evaluative assessment framework.

## Characteristics of Effective Intervention Programs

For the characteristics of BACKtoLIFE to be effective, researching similar program models will be essential when developing this model of the program. Correlations for BACKtoLIFE are minimal because of untested theoretical models within group, family and individual settings. The literature on effective characteristics of cognitive behavioral therapy for adolescents could provide some valuable insight. “An accurate review of the core features of cognitive-behavior therapy and the distinctive characteristics of adolescence leads smoothly to a description of specific intervention procedures” (Franks, 1993, p. 2). The therapist can gear specific problems through assessment formats, intervention, and appropriate measuring instruments. While attention should be given to peer, family, and academic-related problems, while looking at the

depression and anxiety that occur in all of these domains (Franks, 1993). This program will address all aspects through each individual therapy session required for treatment of depression. While reviewing multiple research approaches this program will implement nine variables to ensure its overall success. Those variables are incorporating theory-driven models, assessments and outcome measures, a comprehensive approach to interventions, inter active involvement through stages of the program, well-trained clinical staff, social interventions, experience interpersonal emotions, opportunities for developing and building positive relationships, and clear and precise commitment to activities required to complete program (Franks, 1993).

## Matching Programs to Target Groups

Over time the increase of adolescents developing depression has been caused by bullying, peer pressure, academic stress, and environmental/family distress. Therapy skills learned through individual pet therapy, relationship building through family and group will provide tools to manage depression to "live indefinitely for excellence." The skills can help her with maintaining and repairing relationships, building secure relationships, becoming her own advocate in future goals by speaking out, communication, problem-solving family dilemmas, maintaining positive emotions, managing anxious feelings and self-awareness. Cognitive Behavior Therapy is a type of therapy that focuses on the adolescence cognitive intake that drives behavior (Mothersill, 2016). This writer believes that cognitively how people intake the world around them or the experiences that one endures will drive their behaviors such as the way they think, believe, feel, and/or development of ones desires, then behaviorally it will manifest in

one person's actions to specific areas of their life. Therapists can, through this type of therapy, help adolescents become self-aware, and to gain insight into the ways in which past experiences are affecting their current behavior. Animal Assisted therapy was incorporated to use the natural bond of animals to supply hope, relationship building, and unconditional love with no expectations of returned favors. An animal has very few desires and demands, they need food and water but their unconditional love and trust builds from simple interactions and develops into a lifelong devotion. They become our family, confidant, calm blanket, and protectors. We can be whoever we want and they do not judge, punish or belittle us. Animals allow us to experience emotions and trust in which many are lacking in their relations with humans. The main goals of combining CBT and AAT Therapy was designed to help adolescents gain insight into what has triggered their depression so that they can examine all aspects of their life, experience positive emotions, while addressing unresolved issues and/or conflicts within relationships.

## Program Implementation

The implementation plan for BACKtoLIFE will guide the clinical staff in the direction of the program Excellence Model. The program implementation will be effective as long as clinical staff follows the program objectives as presented in the proposed model (program summary in Appendix B), all staff members will be well-trained and well diverse in the theoretical models and receive on-going training (Appendix H), and conduct ongoing evaluation of the program. The strategies for

implementing the plan will be through guidance of a lead psychologist, multiple level activities, timelines, coordinated tasks and resources.

Lochman et al. (2009) emphasized that with the increase of programs there have been few attempts to evaluate the implementations of the program. When they are widely dispersed and have been adopted in mental health has led to the failure of setting an effective intervention which cause the quality of program implementation to be highly variable (Lochman et al., 2009). Lochman et al. (2009) stresses that organizational support is essential for new programs while being adequately implemented. “The social environment of the organization, and the relationships among individuals in the work setting, are critical characteristics of the organization and are evident in the patterns of control, autonomy, and cohesive communication among workers and supervisors” (as seen in Lochman et al., 2009; see also Weich & Quinn, 1999). Understanding this concept can add to the success while these characteristics can potentially influence the implementation and outcomes of preventive interventions (Lochman et al., 2009).

Kingston, Mihalic and Sigel (2016) stressed that the first step when selecting an evidence-based system of supports based on the need of the program. The second step should involve ensuring that programs are implemented with fidelity as intended to achieve results compared to those found in research trials (Kingston et al., 2016). Successful implementation can be a complex process and can be greatly facilitated by the use of an intermediary organization that facilitates the adoption, implementation and sustainability of evidence-based programs (Kingston et al., 2016). Most programs will consist of considerable variability in which programs are implemented while at time not

staying on track of the core components of a program design. Variations will not be approved for the implementation of the BACKtoLIFE design.

## Program Evaluation

A 1992 conference on "Evaluation in Professional Psychology" was a way to evaluate the professional competency of students (Peterson, Peterson, Abrams & Stricker, 2006; see also Grip, 1994). Peterson et al. (2006) explained "that in developing the educational paradigm endorsed by NCSPP Standards include five areas such as multiple roles, the self of the professional psychologist and reflective practice—practicum and internship training, and systematic evaluation" (p. 2). The indicated prevention (one who has depressive symptoms) and selective prevention (one who is at risk for developing depression) are targeted for interventions when focused specifically on depression (Spence, Sheffield & Donovan, 2003; see also Gordon, 1987). This program will use the evaluation process to measure and provide documented levels of success through treatment.

BACKtoLIFE will have expected outcome measures with the use of the BDI, RADS-2, STAI, IPPA-R and FAM III, while measuring if there is a decrease in psychological distress, resiliency and increase of emotional wellness. The Family Assessment Measure III is a self-report instrument that provides quantitative indices of family strengths and weaknesses and is being administered to measure family functions in different areas (i.e., task accomplishment, role performance, communication, affective expression, involvement, control and values and norms). It will be used to examine family dynamics with participating parents within the family to determine the proper therapy techniques and goals during the family sessions. This assessment will guide the

direct needs for each specific participant throughout the program. BACKtoLIFE will implement the opportunity for all participants to provide qualitative feedback and recommendations from the BACKtoLIFE Feedback Survey (Appendix J). For BACKtoLIFE, a program evaluation will be implemented by collecting results from the pre and posttest measures and the data collected from in the initial assessments.

The Beck Depression Inventory which measures characteristic attitudes and symptoms of depression and is a valuable option to evaluate programs. The BDI can be administered within ten minutes and gives insight into specific struggles that can be targeted during therapy. It can be used multiple times during the program because of the time duration it takes to complete.

Reynolds Adolescent Depression Scale-2 (RADS-2) is an ideal tool to screen for adolescents with significant depressive symptoms within schools or individual practice setting. When determining the standard (T) scores, while following the associated clinical cutoff score of the RADS-2 the clinician is provided with a severity level of the individual's depressive symptoms. This assessment can be given in less than 15 minutes and provides the clinician with additional comparisons with the BDI of depression levels. This strengthens the caparison abilities throughout the program while evaluating its positive outcome at the end of the program.

The State-Trait Anxiety Inventory (STAI) is a commonly used measure of trait and state anxiety, it is mostly used to diagnose anxiety and to distinguish it from depressive syndromes. The STAI is an assessment that can be administered in less than ten minutes and looks at a person trait, which are levels of anxiety long term, while the state is looking at the anxiety levels in their current emotional distress state. The

Inventory of Parent and Peer Attachments reviews the relationships the adolescent has with parent and friends while measuring deficits in attachment. These measurements were developed to require the implementation of evaluation to assess the effectiveness of the program. Initially and annually the evaluation process will include a need for funding and will be included in the budget as evaluation expenses. The Feedback survey which provide progress and possibly improvements of the program moving forward. The assessment measures *(*i.e., BDI, RADS-2, STAI, IPPA-R and FAM III) are utilized to measure symptomology levels and the decrease in psychological distress.

To evaluate the BACKtoLIFE Cognitive Model will be imperative to measure the overall effectiveness of BACKtoLIFE and to determine if the implementation has met the desired goals and objectives.

BACKtoLIFE will implement the following components of the program evaluation:

## Intervention Ideology

BACKtoLIFE is intended to be a therapeutic program designed to reduce psychological distress by increasing emotional wellness and reducing relapse frequency. The program will additionally provide psychoeducational information, the opportunity to interact with peers that are going through similar emotional distress, relationship building skills, and the experience of bonding with canines that are in need of similar emotional connections. BACKtoLIFE will follow specific techniques of other similar supported programs that have demonstrated effectiveness through the use of pretest and posttest measures after implementation and evaluation phases. Assessment formats, appropriate measuring instruments and intervention strategies geared toward specific problems are presented in sufficient detail for replication by the therapist. Attention is

given to family, peer and school-related problems, and the depression which can occur in all of these domains. Parent-skill training is not neglected.

## Intervention Goal

The interventions designed for BACKtoLIFE is designed to address any harmful effects from life stressors and experiences in adolescent participants. Others have found that thoughts that cut across the main cognitive theories of depression and are considered to be central to the development of depression can (Carter & Garber, 2011; see also Garber, 2007). Stark et al. (2012) explained that only when the parents attended six or more of the parent training meetings was the development of the cognitive triad capable in parent–child interactions. In addition, failure of parents to attend the majority of the meetings actually had a negative impact on perceptions of parent–child interactions (Stark et al. 2012). In many programs there are participates that do not complete all aspects needed to become successful in the emotional growth required or do not show up for sessions that are required for completion. The goal for BACKtoLIFE is that the intervention impact will have a positive affect for a life time with minimal continued interventions as needed for the future emotional struggles. The main idea for BACKtoLIFE is to develop a meaning of life.

## Program Readiness

BACKtoLIFE will be available for implementation once the readiness of establishing the organizational staff, training, technical assistance, therapy pets, funding and other support. Part of the preparation of the process will be reflecting on progress, proposing solutions/directions to respond to issues and challenges. The BACKtoLIFE

will implement a multiple participatory evaluation process. With the participatory evaluations, the following strategies will be followed:

1. Setting up frameworks for measuring and reporting results:
    - Who will be evaluated?
    - Who will be involved?
    - When activities will take place?
    - What methods will be used?
    - How findings will be consolidated and results shared?

## Program Budget

BACKtoLIFE funding that will be require to support the cost of the overall program including staff salaries, pet expenses and operational costs. The program will seek out grant funding from local, state, and federal agencies that support programs for adolescents in preventing mental health disorders and providing interventions through psycho-educational modality. This program will include a yearly budget for potential sustainability. In recognizing budget cost, this program can be made available to all adolescents that struggle with mental health issues and questioning youth regardless of socioeconomic status. BACKtoLIFE will actively seek out on-going funding through applicable local, private, state and national grants and foundations to maintain the sustainability of the program.

At the local level, there will be relations built with city foundations, shelters, and churches while establishing grants with nearby cities. At the state level, the State of Texas offers state program grants through the Texas Department of State Health Services for adolescents regarding mental health. For the national level, federal grants are offered

through Health Resources and Services. Additionally, the World Wide Web and mental health websites can provide other resources for possible grants.

BACKtoLIFE will implement a strategic financial planning. The strategies FOR financial planning for this program will consist of

1. Generate and maintain funding resources
2. Establishing relations with available resources
3. Maximizing available types of funding
4. Increase flexibility in existing funding
5. Advocate for local, state, and federal funding resources

The program will be established in an existing practice. The following section is the design of the yearly budget requirement for the sustainability of BACKtoLIFE. The programs budget (Table 1) includes staff salaries, assessment materials, therapy pet care, and operational cost of the program. The budget is established as an estimation to guide in the development phase of the program; in the actual development phase and ongoing the actual costs may demonstrate some fluctuations based on year-to-year economic difficulties.

Start-up costs for BACKtoLIFE

- 200 square ft. barn (feed room, sink, tub, electric, heat and air) : $25,000
- Chain link fencing for 10 indoor and outdoor runs: $2,500
- Food, food and water bowls, leaches and collars : $700.00
- Monthly kennel personal: $720.00
- Monthly barn utilities: $200.00
- Internet Web Page for Adoptions of therapy pets: $200.00

- Office Supplies to include Assessment Measures: $1200.00
- Staff salaries for 120 days 3 hours a day, 360 hours: $5400.00 per staffer

The average cost of a group therapy session averages $45 to $65 (6 sessions) per person per group session. The average cost of a family therapy session averages $45 to $65 (6 sessions) per person per family session. Individual therapy cost can average from $55 to $175 per session; averaging $660 to $2,100 for twelve sessions for licensure level of the mental health provider. For a clinical assessment by a clinical psychologist can average from $80 to $200. For the cost of a participant in BACKtoLIFE is based on the lower end of the costs mentioned above estimating at $1,200.00. If the participant does not have medical insurance to cover the cost of the program, the participant will be covered by the fundraising or grant funding. Reed (2010) emphasized that clinical utility affects the daily lives of practitioners and is also a global public health issue while most people with mental disorders worldwide receive no treatment. In helping the World Health Organization (WHO) member countries reduce the disease burden of mental disorders a diagnostic system with greater clinical utility can be a tool to improve identification and treatment. Understanding and utilizing the ICD-10 and DSM-5 while diagnosing will assist in managing treatment and providing an appropriate reimbursement for the psychologist. In other words getting reimbursed by those with insurance can open the abilities for assisting others with no insurance.

In conclusion, with a budget of $59,880.00 per year, (Table 3.) BACKtoLIFE will facilitate on average of 20 participants per year that can benefit from the psychoeducational group modality.

Table 3. Budget Plan

| Expenses | Annual Cost |
|---|---|
| **Clinical Psychologist** | $35,000.00 |
| **Administrative Staff** | $5400.00 x 3 = $16,200.00 |
| **Office supplies & Assessment measures** | $1200.00 |
| **Internet Web Site** | $200.00 |
| **Barn Utilities for 24 weeks** | $800.00 |
| **Feed & Maintenance care** | 150.00 per week x 24w = $3600.00 |
| **Kennel Staff** | $720.00 per month x 4 = $2880.00 |

*Note*. Bonding with Animals with Compassion for Knowledge to Live Indefinitely For Excellence Program Estimated Yearly Budget

## Program Location

BACKtoLIFE will occur twice a year (i.e., spring and fall) and program will incur costs for the therapy pets, utilities and pet maintenance. The therapy will be conducted at a pre-existing psychological office. This office will already have several rooms to provide group and family therapy sessions and existing outside facilities with private areas for therapy. The facility will be geographically located to accommodate the local community. The budget will cover all operating costs during the 24 weeks that the program will be in session. This will include a program design with a dedicated facility location that will support the program design and ongoing crisis intervention.

BACKtoLIFE will be available for the implementation for various animal shelter in the nearby communities, since part of their program will be volunteering to help pet in need. The program will incorporate surrounding foundations, while our mission will be

to bring awareness of the growing deficit of depression within our adolescent population. The participants will be encouraged to develop community programs to reach other adolescents that may be struggling and learn the importance of community outreach messaging.

## Summary

The development of BACKtoLIFE and the components were devised from documented research studies regarding the increase of depression within the adolescent population. This includes the Cognitive Behavioral Theoretical Approach while combining Animal Assisted Therapy. BACKtoLIFE incorporates experiences that many adolescents are lacking in their emotional attachments. This model's goal is to guide their negative thoughts and actions that have led to them developing depression, while instilling a more positive emotional thought process. This process will allow them to begin developing positive relationships with humans with the use of animals. The main goal is to keep the cost down low enough or have coexisting relationships with local, state and government foundations so all adolescents have the opportunity to enter the program.

# CHAPTER 5. DISCUSSIONS AND CONCLUSION

## Summary of the Results

The purpose of this proposed program is to develop a therapy process that includes a combination of cognitive behavioral and animal-assisted therapy specifically designed for female adolescents. The program was designed with current literature that can be used to address the reduction of psychological distress of depression and attachment distress. This program was developed with statistical data regarding adolescents and the rise of depression within this population. Bonding with Animals with Compassion for Knowledge to Live Indefinitely For Excellence (BACKtoLIFE) is a comprehensive multi-therapeutic program that provides three specific interventions that include individual, family and group sessions to build emotional relations with the use of a therapy pet. This program includes an implementation and an evaluation plan. This final chapter will outline the summary of results, funding issues, practical issues, limitations of the proposed program, future recommendations of research, and conclusion.

This proposed program is designed as a combined theoretical process of cognitive behavior and animal assisted therapy while promoting positive relationships and emotions. This was designed as a combination of two therapy processes with the goal of an extended efficacy rate and positive emotional outlook for future success. It will include family involvement in order to gain healthy relationships and narrow the gap in emotional distress between the adolescent and parent. There have been studies that have linked family conflict to adolescent depression (Stark et al., 2012). It will involve group therapy with peers that are struggling with similar emotional distress. They will

have the ability to experience team building activities while expressing their feelings in an open dialog. The statistical data of the Department of Health and Human Services, explains “that more than three million adolescents aged 12-17 reported at least one major depressive episode in the past year, and more than two million reported severe depression that impeded their daily functioning” (Schrobsdorff, 2016, p. 5). Schrobsdorff (2016) reported “that the most common risk for depression is being female because statistical data reports that rates of depression among girls ages 12-17 in 2015 were more than double that of boys” (p. 5). (In the U.S., 19.5% of girls experienced at least one major depressive episode in the last year, while only 5.8% of boys did.)

Adolescents continue to experience mental health disorders through many avenues. They could develop depression from family genetics or emotional distress within the home. Some studies have reported that peer pressure, personality disorders, and loss of loved ones and/or economic despair can cause them to spiral into a depressive state. Some other stressors that can cause an adolescent to become depressed can be academic struggles and social anxiety. This program will address all aspects of the participant’s life experiences through a complete history, in order for therapy to be developed to address the initial cause. The program will develop therapy to address family, peer and individual emotional distress. They will experience interactions with others in similar distress while building positive relations to build self-esteem and confidence.

Animal assisted therapy has been proven to help in many health ailments such as high blood pressure, cancer, heart issues and many more. It has been documented that for shared need for shelter, food, and protection were mutual needs of human and animals when domestication and socialization began between the two (Walsh, 2009). “Over

recent decades, companion animals have become increasingly important in the lives of Americans" (as seen in Walsh, 2009; Grier, 2006). Walsh (2009) reported that the term companion animals has become the preferred term to connote a psychological bond and a mutual relationship in the professionals of veterinary medicine, animal welfare, and human-animal. "Pets also have been found to influence the course and optimal functioning with pervasive developmental disabilities in mental health such as depression" (Walsh, 2009; see also Martin & Farnum, 2002). Many professionals have established that interactions with pets alter the tendency of those with mental problems to focus negatively on themselves due to becoming more involved in their environment in nonthreatening ways with a companionate animal (Walsh, 2009).

BACKtoLIFE hopes to provide additional treatment options for other clinical professionals in implementing a research-based program. This program will strive to expand the field of psychology through the understanding of the psychological distress in the adolescent population. The contribution of this program to the mental health field is essential to increase processes for adolescents while promoting peer advocacy with companion animals. It will strive to provide valuable resources for clinical therapists in the local and surrounding community.

There are many goals for this proposed program evaluation. First, the goal is to assess the program design and efficacy of the interventions for the purpose of reducing depression. The purpose of the design will be established to help to improve the accountability and overall effectiveness of BACKtoLIFE. Secondly, to monitor progress towards goals with assessment and depression scales, measure and producing desired progress on expected outcomes, provide the need for further support and funding while

providing an additional process for the success of treating depression among adolescents. Thirdly, the evaluation plan for BACKtoLIFE will utilize an evaluation process with pretest and posttest outcome measures (i.e., BDI, RADS-2, STAI and FAMII) to measure the decrease in depression. BACKtoLFE's impact will establish a positive intervention sustainability of 12 weeks after the completion of the program. This timeframe will provide a demonstration with positive effects as evident by the decrease of depression and building positive relationships. Currently there are no other programs designed for adolescents with this combination and rigorous therapy process.

## Feasible Issues

To get BACKtoLIFE up and running it will be essential to conduct several presentations about the program and the goals of the program throughout the community. The community will be appraised of the program design and goals for providing assistance with treating adolescent girls with depression. The clinical staff will be well-trained in the various interventions and have the knowledge of the critical issues with depression, duty to warn and documentation needed for each participant entering into the program. Introduction of the therapy pet will be essential; a clear understanding of the roll of the participant and therapist in the care of the pet and the process in which the pet will play during therapy. The last issue to consider will be the efficacy of the program while striving to extend the effects of treatment for future success. It will be essential that the confidentiality, dismissal, and exclusion policies will be discussed thoroughly with each participant.

## Training Issues

The license psychologist will be the sole person to ensure direction and management of all aspects of the program. The psychologist will train and prepare the administrative staff in their duties and role (e.g., office personnel, possible interns, and shelter staff). All clinical staff working for BACKtoLIFE will be required to attend a 20 to 30 hour training to ensure knowledge of the program design, legal and ethical standards. Before each program sessions in the spring and fall, there will be a training course and meetings to discuss improvements, implementation of new ideas or discuss negative instances while developing solutions.

## Funding Issues

BACKtoLIFE will strive to gain funding from local, state or federal foundations to avoid participants from not being able to enter the program due to economic status. The program will work to bring awareness of care needed to house and feed the therapy pets and provided adequate care during the program. Those participants that have Private or Medicaid insurance, the fee for individual therapy sessions will be $86.95, and $42 for the psychoeducational group and family sessions. At the initial appointment, it will be determined if the participant will use their insurance or receive assistance from foundational funds.

## Limitations

While developing the BACKtoLIFE program there are some limitations that need to be considered. This program is a very rigorous program that will require three types of therapy. Therefore, one limitation will be the participation of the parents and their agreement in meeting all requirements. In the state of Texas any adolescent under the

age of 18 is unable to consent to psychological services unless he or she does not live in the household and able to support themselves financially. Adolescents with divorced parents that have joint custody, the State of Texas requires that both parents sign consent for psychological services. Any of these scenarios can be viewed as possible limitations for any adolescent to be able participate in BACKtoLIFE.

The ability to pay due to lack of insurance or economic status could be a limitation in being able to participate in the program. Participants leaving without notice or becoming noncompliant and disruptive that requires removal of the program can be another limitation. Some other limitations can be inaccurate data on the self-reporting measures or participants not disclosing symptoms that hinder their therapy process (suicide ideology). If the participant has a fear of dogs or transportation issues in order to make all their appointments and volunteering schedule at the local shelter, finally the last limitation would be if the participant doesn't want to participate in group or family therapy sessions required to complete the program. Discloser of these limitations will be brought to the attention of the license psychologist. The overall effectiveness of the program will not be factor in regards to participates.

## Recommendations for Future Research

BACKtoLIFE was developed as a combined therapy model to utilize therapy pets for adolescents to experience human animals bonding while promoting healthy relationships bonding. Depression has drastically increased in the adolescent population over the last decade. Although we focus on females this program will be available for any adolescent regardless of their race, ethnicity, gender identity, and sexual orientation. "A broad range of investigations have found that animal-human interactions reduce anxiety,

depression, and loneliness as they enhance social support and general well-being" (Walsh, 2009; see also Friedmann & Tsai, 2006). Research has added to the recognition of the rise of depression and provided therapy processes that are more effective regarding treatment options. Additional research will add to the awareness of the rise of depression with adolescents while providing additional treatment options. The research has provided other professionals to seek other programs to add to the duration of treatment with depression. Recommendations for future research is to develop and demonstrate the effectiveness of additional interventions. BACKtoLIFE will allow for adjustments and refining of the combined therapy process. This program will strive to add to the success rate and future decline of depression in the adolescent population.

In the past several decades research supports the rise of depression in the adolescent population. Many authors propose that one of the pathways that lead to development of depression is the cognitive-interpersonal pathway derived from the cognitive model of depressive disorders (Stark et al., 2012; see also Beck, Rush, Shaw, & Emery, 1979). For this program, available resources can be internet-based, community centers, hotline, foundations, churches and advocacy programs. For future goals as the program is established possible training and implications can be spread through other communities and geographical areas across the nation.

## Conclusion

In the conclusion of this program of BACKtoLIFE the goal is to contribute to providing additional therapy options for other clinical and professionals that work with depressed adolescents, while addressing anxiety and suicide ideation which can go hand in hand with depression. This program was designed with the goal to extend the efficacy

of treatment for a more productive future. Although, this program will focus on females, the success of the program and ability to extend the efficacy rate of treatment for depression will benefit either gender. BACKtoLIFE will provide a rigorous program with effective interventions that will guide cognitive behaviors in positive thoughts processes while adding the experience of bonding with animals. BACKtoLIFE will have a strong need to provide the local community with care and hope for abandoned animals as our goal is to place them in loving adopted homes at the end of the program. When the utilization of these therapy pets are incorporated into therapy in a positive emotional process, the adolescent will experience emotional bonding through compassion and love that will build their own self-esteem and grow a positive outlook for future goals. The need for this type of program was developed because of the rise of depression in the adolescent population, while researching existing programs that lack the incorporation of animal therapy. Finally, BACKtoLIFE will strive to open doors for future endeavors and provide many adolescents with the ability to see a positive future.

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## APPENDIX A. INDIVIDUAL THERAPY SESSIONS FOR ADOLESCENT FEMALES

Goal of Individual sessions:

The participant will have the chance to learn about the critical issues that affect the female adolescent population. To understand and reduce psychological distress by achieving relationship building skills, gain resiliency to bridge a brighter future and the skills to future emotional constraints. These sessions will go where the adolescent is while developing goals and homework. They will assist in the care and husbandry of their therapy pet with clear understanding of the adoption process after the program is completed. These sessions could be held in various areas of the practice but mostly outside when weather permits, these sessions may involve different therapy techniques, and will be designed to meet their individual needs for a successful intervention process. During the interaction of the therapy pet they will be cleaning, feeding and training while just spending quality time interacting with the pet. They will give input into people that could provide a forever home for the pet after the program ends.

Individual Sessions

*First Session:* Discuss their roll in caring for therapy pet and discuss identified critical issues that caused depression, measure level and discuss assessment outcome. Explain the process of setting goals and implementing a goal list for next session.

*Second Session:* Discuss goals for therapy while interacting with therapy pet and develop homework.

*Third Session:* Discuss past week, any success or set back of chosen homework while interacting with therapy pet.

*Fourth Session:* Discuss past week, any success or set back of chosen homework while interacting with therapy pet.

*Fifth Session:* Discuss past week, any success or set back of chosen homework while interacting with therapy pet.

*Sixth Session:* Discuss past week, any success or set back of chosen homework while interacting with therapy pet, assessments to measure depression levels.

*Seventh Session:* Discuss past week, any success or set back of chosen homework while interacting with therapy pet.

*Eighth Session:* Discuss past week, any success or set back of chosen homework while interacting with therapy pet.

*Ninth Session:* Discuss past week, any success or set back of chosen homework while interacting with therapy pet.

*Tenth Session:* Discuss past week, any success or set back of chosen homework while interacting with therapy pet.

*Eleventh Session:* Discuss past week, any success or set back of chosen homework while interacting with therapy pet.

*Twelfth Session:* Discuss past week, any success or set back of chosen homework while interacting with therapy pet, complete final assessments, measure depression, conclude and discuss future goals.

## APPENDIX B. BACKtoLIFE PROGRAM SUMMARY

1. *Program Objectives*
   a. Reduce psychological distress (i.e., depression)
   b. Provide interventions and information regarding identified critical issues
   c. Implement positive emotional experiences and resilience

2. *Participants*
   a. Female Adolescents age 13- to 17-years-old
   b. Therapy Pet
   c. Parents or guardians

3. *Assessment Measures*
   a. Beck Depression Inventory (Beck, et al., 1961)
   b. The Reynolds Adolescent Depression Scale-2 (SIGMA, 2017)
   c. The State-Trait Anxiety Inventory (Raymond Cattell, 1961)
   d. The Family Assessment Measure (Multi-Health Systems, 2017)
   e. The Inventory of Parent and Peer Attachment–Revised (National Council on Family Relations, 2017)

4. *Admission Criteria*
   a. All Adolescent females diagnosed with depression aged 13- to 17-year-old
   b. All parents and guardians

5. *Exclusion Criteria*
   a. Any youth or adult demonstrating potential danger
   b. Any youth or adult under the influence of drugs and/or alcohol

6. *Program Frequency and Duration*
   a. Program will run 12 weeks in the Spring and Fall
   b. Individual therapy is once a week
   c. Volunteer day at shelter is required once a week
   d. Group sessions scheduled for every other week with a total of 6 sessions (opposite week of family sessions)
   e. Family sessions scheduled for every other week with a total of 6 sessions (opposite week of group sessions)

7. *Physical Environment*
   a. Location for all therapy sessions is onsite at clinical office.
   b. Facility with indoor and outdoor facilities adequate for sessions
   c. Space comfortable for use of media equipment or needs presented in therapy sessions

8. *Dismissal*

a. Violating confidentiality
b. Continual absences without appropriate excuse
c. Displaying verbal aggression and threats
d. Under the influence of drugs/alcohol

9. *Facilitator Qualifications*

a. Licensed Clinical Psychologist
b. Licensed Professional Counselor or Licensed Clinical Social Worker
c. Foundation in Cognitive Behavioral Approach, training in the Animal Assisted Therapy, and culturally competent in Adolescent population

10. *Initial Interview (Adolescent and Parent or Guardian)*

a. Discuss Confidentiality for all participants
b. Discuss Duty to Warn
c. Sign all Forms
d. Discuss everyone's participation duties
e. Discuss Termination process
f. Set all dates for sessions for adolescent, family and group therapy
g. Set day to pick therapy animal and transport to psychological facility, while at shelter they will schedule their day of week for volunteering at Shelter
h. Complete assessment forms and measure the level of depression

11. *Individual Sessions*

a. First Session: Discuss their roll in caring for therapy pet and discuss identified critical issues that caused depression, measure level and discuss assessment outcome
b. Second Session: Discuss goals for therapy while interacting with therapy pet and develop homework
c. Third Session: Discuss past week, any success or set back of chosen homework while interacting with therapy pet
d. Fourth Session: Discuss past week, any success or set back of chosen homework while interacting with therapy pet
e. Fifth Session: Discuss past week, any success or set back of chosen homework while interacting with therapy pet
f. Sixth Session: Discuss past week, any success or set back of chosen homework while interacting with therapy pet, assessments to measure depression levels
g. Seventh Session: Discuss past week, any success or set back of chosen homework while interacting with therapy pet
h. Eighth Session: Discuss past week, any success or set back of chosen homework while interacting with therapy pet

i. Ninth Session: Discuss past week, any success or set back of chosen homework while interacting with therapy pet
j. Tenth Session: Discuss past week, any success or set back of chosen homework while interacting with therapy pet
k. Eleventh Session: Discuss past week, any success or set back of chosen homework while interacting with therapy pet
l. Twelfth Session: Discuss past week, any success or set back of chosen homework while interacting with therapy pet, complete final assessments, measure depression, conclude and discuss future goals

12. *Group Sessions*
a. First Session: Introductions, group rules, and discuss identified critical Issues of
Adolescent depression
b. Second Session: What does it mean to identify as a female adolescent, self-awareness and team building exercises
c. Third Session: Psychological distress, open discussion and team building exercise
d. Fourth Session: Stress, social distress, bullying and team building exercise
e. Fifth Session: Developing open communication skills/How to speak up for self
f. Sixth Session: Building relationships and Resources for adolescents/Conclude

13. *Family Support Sessions*
a. First Session: session rules and discuss identified critical issues of Adolescent with depression
b. Second Session: What does it mean to parent of a child with depression and building relationships
c. Third Session: Understanding the adolescents feelings and thoughts, open discussion, role playing
d. Fourth Session: Developing open communication skills/How to talk to my adolescent
e. Fifth Session: Communication skills and exercise, role playing
f. Sixth Session: Open discussion and relationship building exercise, assessment measure, Conclusion

14. *Facilitator and Counselor Resources*
a. American Psychological Association, ethics addressing adolescent and family therapy
b. Cognitive Behavioral Therapy Approach
c. Animal Assisted Therapy
d. Family therapeutic Assistance

e. Adolescent Population

## APPENDIX C. BACKtoLIFE CODE OF ETHICS OF ANIMAL-ASSITED THERAPY

Animal assisted therapy has increased over the past 20 years. This program has developed its own ethical codes regarding the therapy pets used for program duration. To provide ethical direction for the psychologist, facility, and participants to endure no harm is done to the pets during the program.

a. The Animal-assisted therapist and staff will meet the professional requirements for this program and all State requirements.

b. The Animal-assisted therapists must be aware of their responsibilities and duties, and adhere to the regulations set forth in this document.

c. The Animal-assisted therapists and staff must comply with the laws of the State of Texas, all laws pertaining to mental health, welfare and education, as well as all derivative regulations included in the Texas' anti-cruelty laws.

d. Patients may do no harm of any kind to their therapy pet. Should a patient maim or even kill an animal, the therapist must act both according to the needs of the patient and with regard to the specific incident, and of course, follow all guidelines set forth by the State of Texas penal code and cruelty laws.

e. The Animal-assisted therapists must diagnose, treat and advise only within their areas of expertise, and in accordance with their professional training and experience. They must inform patients or their guardians of their relevant education, skills, specialization and occupational experience before proceeding with treatment.

f. The Animal-assisted therapists must act with integrity and dignity towards patients and other professionals. When acting as part of a multi-disciplinary team, animal therapists must cooperate with other therapists and staff for the good of the patient. They must avoid forcing their personal beliefs and work methods with different animals on their patients.

g. Animal-assisted therapists must accept wholeheartedly the complexity and disparity of patients and their views.

h. Animal-assisted therapists must broaden their familiarity with as many cultures, traditions, religions and faiths as possible, with the understanding that such knowledge may prove beneficial to patients during sessions. Therapists must be aware of their convictions, opinions, and biases, as well as those of their patients, before taking on the responsibility of treatment.

i. Animal-assisted therapists must be aware of the possible effects of therapy and the relationship dynamic with the animals they employ. Therapists must understand the cultural significance and symbolism of the animals they work with.

j. Animal-assisted therapists must maintain the highest measure of professionalism and keep up with new developments in the field.

k. Animal-assisted therapist must oversee and assist in maintaining all husbandry required for the care of the therapy pet, including housing, food, fresh water, health such as vaccinations and heartworm preventative. Observation of animal behavior and take appropriate measures if the pet becomes ill or exhibit behavior changes.

## APPENDIX D. DISMISSAL POLICY

The following are rules set forth for Bonding with Animals with Compassion for Knowledge to Live Indefinitely For Excellence Program

1. Participants who miss more than two (2) consecutive sessions (individual, group, family or volunteer time) without prior notice will be removed from the program, but with the option to rejoin at a later time.
2. All individual, family, and group sessions will have a set start and end time. Each participant is required to be on time.
3. No drugs or alcohol allowed on the premises. Any participant that is under the influence of drugs or alcohol will not be allowed to attend the session.
4. Any personal information shared in the group sessions is to remain confidential and is not to be discussed outside of the group.
5. Any personal information shared in the family sessions is to remain confidential and is not to be discussed outside of the family to ensure trust.
6. For absences, please notify staff, if possible 24 hours before any session. If not, then two (2) hours before the start time of the sessions.
7. Electronics are not allowed in any sessions.
8. Outside drink and food not allowed unless prior approved by clinical staff for special occasions. BACKtoLIFE will supply drinks and a snacks for sessions.
9. Disruptive behavior will not be tolerated in the sessions.
10. The participant will conduct themselves in the same manner while volunteering at the animal shelter.

I, ______________________________ agree to abide by the above terms of the BACKtoLIFE Program sessions and at the animal shelter. If I am not able to follow these rules, I agree to discuss this with the clinical staff. I understand that violation of these rules may result in dismissal from the program.

Signature of Adolescent _____________________________ Date _____________

Clinical staff _____________________________________ Date ________________

## APPENDIX E. NO-HARM CONTRACT

I____________________________, agree to ***not*** harm myself in any way, attempt to kill myself, or kill myself during the period from ________________ to ________________ (the time of my next appointment). I agree that, for any reason, if the appointed session is postponed, canceled, etc., that this timeframe will be extended until the next direct meeting with the clinical staff. In this timeframe, I agree to care for myself, to eat well, and to get enough sleep each night.

I agree to make social/family contact with the following individuals:

______________________________________________________________

______________________________________________________________

______________________________________________________________

I agree to rid my presence of all things I could use to harm or kill myself. I agree that, if I am having a rough time and come to a point where I may break any of these promises, I will call and make significant contact with any of the following individuals:

________________________________________at # ____________________________

________________________________________at # ____________________________

Or, if I cannot contact these individuals, I will immediately call the

Suicide Crisis Hotline at# ______________________________

I agree that these conditions are important, worth doing and that this is a contract I am willing to make and keep. By my word and honor, I intend to keep this contract.

Signed ______________________________________ Date ______________________

Witnessed by __________________________________Date _______________________

## APPENDIX F. FAMILY SUPPORT GROUP SESSIONS TOPICS

**1.** First session:
Introductions, establish ground rules, session rules and discuss identified critical issues of an adolescent with depression.

**2.** Second session:
What does it mean to parent of a child with depression and the importance of building healthy relationships. Introduction of Love and Logic Parenting.

**3.** Third session:
Understanding the adolescent's feelings and thoughts, open discussion, and waited vest exercise. Review of Love and Logic parenting through written communication or private conversation.

**4.** Fourth session:
Developing open communication skills/How to talk to my adolescent and role playing. Review of Love and Logic parenting through written communication or private conversation.

**5.** Fifth session:
Communication skills and exercise, tell each other their number fear, and role playing. Review of Love and Logic parenting through written communication or private conversation.

**6.** Sixth session:
Open discussion and relationship building exercise, assessment measure, Conclusion

## APPENDIX G. GROUP DETAIL OF SESSIONS FOR ADOLESCENT FEMALES

Goal of group sessions:

The group participants will have the chance to learn about the critical issues that affect the female adolescent population. To understand and reduce psychological distress by achieving relationship building skills, gain resiliency to bridge a brighter future and the skills to future emotional constraints.

*Group Session 1:* Introductions, group rules, and discuss identified critical Issues of Adolescent depression

Activities: To start there will be group introductions and establishing ground rules for the group. The group rules established for these sessions are the following: attendance, appropriate listening skills, limited confidentiality, trust, respect, raise your hand to speak, no over talking, no swearing, and participation. An explanation of why these group rules are important to the group process.

Identify Emotional distress such as Depression and Anxiety, which will include possible causes such as teen dating, interpersonal relationships, stress, drugs, alcohol, bullying and cyberbullying.

Discuss how each critical issue impacts the female adolescent population.

Homework assignment: What does it mean to identify as a female? Write a short description (1/2 page) and will present in next group session.

*Group Session 2:* What does it mean to identify as a female adolescent, self-awareness and team building exercises

Activities: Review homework assignment: What does it mean to identify as a female? Allow each participant to read their short description. Discuss emotions and feelings surrounding one's identification.

Exercise: Everyone will pair up with someone and talk for 10 minutes, during this time they will learn as much about each other as possible, such as where they are from, what they like, don't like, their birthday and family origins. Then they will be ask to introduce that person and tell about them.

Homework: Set three goals for group therapy.

*Group Session 3:* Psychological distress, open discussion and team building exercise

Activity: Review homework assignment: Share their goals with the group.

Exercise: Eye Contact, they will be paired with someone and ask to stare at each other in the eyes for 60 seconds. Then describe how it made them feel and why it's important to make eye contact when inter acting with others.

Discuss what depression is and provide definitions from DSM-5. Discussion of thoughts, feelings, and emotions regarding depression.

Homework: If you were an animal what would it be and why? Bring a picture with why you identify with the animal written on the back and do not reveal it to anyone.

*Group Session 4:* Stress, social distress, bullying and team building exercise

Trust and Recognition

Activities: Review homework assignment: All pictures will be displayed by therapist the therapist will read the back and everyone will be ask who they think it is and after everyone has answered it will be revealed.

Exercise: Everyone will be issued a card with an animal on it there will be two of the same of every species they will be ask to move around the room with their eyes closed while making the noise that animals makes and the goal is to find their match.

Homework: Write about your current stressor (one paragraph), write about social stress (one paragraph) and write if you have ever been bullied, by whom and what did you do (one paragraph).

*Group Session 5:* Developing open communication skills and how to speak up for yourself

Activities: Review homework assignment: Everyone will read their assignment, while discussing with the group, what others think and feel. Discuss some strategies to manage the stress and becoming comfortable in social settings. Introduce communication skills. Discuss why it is challenging to talk with others and parents.

Exercise: Engage in role-plays in demonstrating effective communication. Everyone will get sticky noted and write what they learned from the session about themselves today and leave them on the board by the door.

Homework assignment: Spend one hour in nature alone, close your eyes feel everything around you, what you smell, what you feel, what you hear and then write about how you felt before and after.

*Group Session 6:* Building relationships and Resources for adolescents/Conclude
Activities: Review homework assignment: Read the assignment to the group. Open discussion about what they have learned from others in the group. Discuss how it is going for them and any struggles. Conclude by asking if anyone needed additional skills or resource for future use.

## APPENDIX H. CLINICAL STAFF TRAINING AND RESOURCES

The training of the facilitators for Bonding with Animals with Compassion for Knowledge to Live Indefinitely For Excellence will consist of the following topics:

1. Cognitive Behavior Approach
   a. What is Cognitive Behavior Approach?
   b. Understanding the CBT approach. Each staff will provide examples.
   c. Each staff will receive a copy of the book, *"Retrain Your Brain: Cognitive Behavioral Therapy n 7 weeks; A Workbook for Mangling Depression and Anxiety"* by Seth J. Gillihan, PhD.
   d. Role-playing examples of building self-esteem, relationship building, and positive thinking

2. Animal Assisted Therapy
   a. Providing literature articles on AAT
   b. Discussion of the process and interaction needs
   c. Care and husbandry of therapy pets
   d. Each staff will receive a copy of the book, *"Animal Assisted Therapy in Counseling"* by Cynthia K. Chandler

3. Cultural Competency
   a. What is Cultural Competence?
   b. How to become Cultural Competent?
   c. They will be required to read a copy of this article: *"Predicting cultural competence: Implications for practice and training"* By Allison, Echemendia, Crawford, & Robinson.

4. Female Adolescent Population
   a. Implement Competence for Counseling Female Adolescent Individuals
   b. Critical issues that female adolescents face
   c. Bias and Struggles
   d. Review of websites and resources for female adolescent population
   e. Ethical considerations

## APPENDIX I. LIST OF RESOURCES

***Support Lines***

The National Suicide Prevention Lifeline

**XXXXX**
Serving XXXX County
Crisis Hot Line
XXX MetroCare Services
24 hours / 7 days

Teen Help Line

**XXXXX**
Serving X Area, Including
XXX and XXX Crisis Line
Suicide & Crisis Center
24 hours / 7 days

***Websites*** 

- Teen Mental Health http://teenmentalhealth.org/learn/mental-disorders/depression/
- Teen Depression Study: Understanding Depression in Teenagers https://www.nimh.nih.gov/health/publications/teen-depression/index.shtml
- Teenagers guide to depression https://www.helpguide.org/articles/depression/teenagers-guide-to-depression.htm
- http://www.about-teen-depression.com/
- www.teensuicide.us - Information on how to prevent teen suicide
- www.teendepression.org - Information on teen depression, issues and other problems
- www.ok2bblue.com - The BLUEWAVE website has been created as a media/portal where youth and parents can learn about the challenges surrounding mental health issues. The underlying message is that we all feel "Blue" from time to time, and that it is: OK2B BLUE
- Therapy Dogs International. (2012). About TDI. Retrieved from:
- http://www.tdi-dog.org/About.aspx
- Pet Partners. (2012b). About us: Our mission and vision. Retrieved from: http://www.deltasociety.org/page.aspx?pid=251
- American Society for the Prevention of Cruelty to Animals. (2012). Pet Statistics. Retrieved from: http://www.aspca.org/about-us/faq/pet-statistics.aspx.
- Austin Animal Center http://www.austintexas.gov/department/animal-protection
- Overview of Texas Animal Cruelty Laws https://www.animallaw.info/article/overview-texas-animal-cruelty-laws

- http://codes.findlaw.com/tx/penal-code/penal-sect-42-092.html
- Texas Suicide

http://static1.squarespace.com/static/558491dde4b09ff6f50e97eb/t/55f892dee4b0faa61d4d2c9b /1442353886915/Suicide_Prevention_2015_Toolkit.pdf

## APPENDIX J. BACKtoLIFE PARTICIPANT SATISFACTION SURVEY

***We would like to know how you feel about the program so we can make sure we are meeting your needs. Your responses are directly responsible for improving this program moving forward. All responses will be kept confidential and anonymous. Thank you for your time.***

Age: _______

Sex:
Female ____

Race/Ethnicity:
___ Asian
___ Pacific Islander
___ Black/African American
___ American Indian/Alaska Native
___ White (Not Hispanic or Latino)
___ Hispanic or Latino (All Races)

| Please circle how well you think we are doing in the following areas: | GREAT 5 | GOOD 4 | OK 3 | FAIR 2 | POOR 1 |
|---|---|---|---|---|---|
| **Program:** | | | | | |
| Ability to start program | 5 | 4 | 3 | 2 | 1 |
| Hours Office is open | 5 | 4 | 3 | 2 | 1 |
| Convenience of Office location | 5 | 4 | 3 | 2 | 1 |
| Valuable of the program in the community | 5 | 4 | 3 | 2 | 1 |
| **Group Sessions:** | | | | | |
| Provided resourceful information | 5 | 4 | 3 | 2 | 1 |
| Time of the group sessions | 5 | 4 | 3 | 2 | 1 |
| Provided safe environment | 5 | 4 | 3 | 2 | 1 |
| **Family Sessions:** | | | | | |
| Provided resourceful information | 5 | 4 | 3 | 2 | 1 |
| Time of the family sessions | 5 | 4 | 3 | 2 | 1 |

| | | | | | |
|---|---|---|---|---|---|
| Provided safe environment | 5 | 4 | 3 | 2 | 1 |
| **Volunteer Time:** | | | | | |
| Was the training at facility knowledgeable | 5 | 4 | 3 | 2 | 1 |
| Were the hours convenient | 5 | 4 | 3 | 2 | 1 |
| Was staff informative | 5 | 4 | 3 | 2 | 1 |
| **Staff:** | | | | | |
| Listens to you | 5 | 4 | 3 | 2 | 1 |
| Takes enough time with you | 5 | 4 | 3 | 2 | 1 |
| Explains what you want to know | 5 | 4 | 3 | 2 | 1 |
| Provides resources | 5 | 4 | 3 | 2 | 1 |

**Additional Comments or Suggestions:**

## STATEMENT OF ORIGINAL WORK

### Academic Honesty Policy

Capella University's Academic Honesty Policy (3.01.01) holds learners accountable for the integrity of work they submit, which includes but is not limited to discussion postings, assignments, comprehensive exams, and the dissertation or capstone project.

Established in the Policy are the expectations for original work, rationale for the policy, definition of terms that pertain to academic honesty and original work, and disciplinary consequences of academic dishonesty. Also stated in the Policy is the expectation that learners will follow APA rules for citing another person's ideas or works.

The following standards for original work and definition of *plagiarism* are discussed in the Policy:

Learners are expected to be the sole authors of their work and to acknowledge the authorship of others' work through proper citation and reference. Use of another person's ideas, including another learner's, without proper reference or citation constitutes plagiarism and academic dishonesty and is prohibited conduct. (p. 1)

Plagiarism is one example of academic dishonesty. Plagiarism is presenting someone else's ideas or work as your own. Plagiarism also includes copying verbatim or rephrasing ideas without properly acknowledging the source by author, date, and publication medium. (p. 2)

Capella University's Research Misconduct Policy (3.03.06) holds learners accountable for research integrity. What constitutes research misconduct is discussed in the Policy:

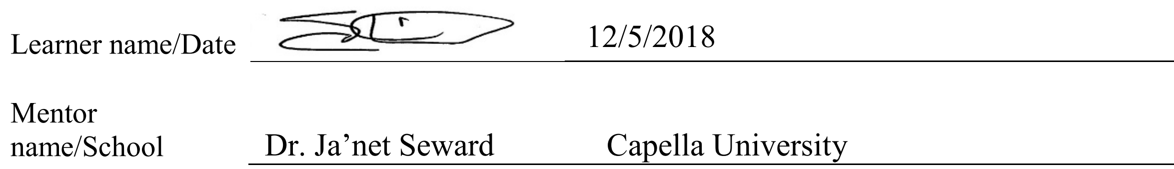
Research misconduct includes but is not limited to falsification, fabrication, plagiarism, misappropriation, or other practices that seriously deviate from those that are commonly accepted within the academic community for proposing, conducting, or reviewing research, or in reporting research results. (p. 1)

Learners failing to abide by these policies are subject to consequences, including but not limited to dismissal or revocation of the degree.

**Statement of Original Work and Signature**

I have read, understood, and abided by Capella University's Academic Honesty Policy (3.01.01) and Research Misconduct Policy (3.03.06), including Policy Statements, Rationale, and Definitions.

I attest that this dissertation or capstone project is my own work. Where I have used the ideas or words of others, I have paraphrased, summarized, or used direct quotes following the guidelines set forth in the APA *Publication Manual*.



| | | |
|---|---|---|
| Learner name/Date | | 12/5/2018 |
| Mentor name/School | Dr. Ja'net Seward | Capella University |