Making the Rounds with the Pastoral Care Dog

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The use of animals in therapeutic settings has been around a long time. Greek mythology tells us that a centaur (half-man, half-horse) was the first physician. We have grave figures from China, dated before Christ’s birth, which depict dogs in harnesses and indicate that those dogs were “working” at some useful function, perhaps therapeutic.

In 1792, a Quaker merchant in England used farm animals in the treatment of the emotionally ill. Less than a century later in Germany, pets were used to treat epileptics as it was found that dogs can communicate an impending seizure before it actually occurs.

At the end of World War II, the American Red Cross used dogs, horses, and farm animals in the rehabilitation of airmen. In the 1960s, a blind man in Norway used dogs and horses to encourage blind and otherwise disabled patients to exercise.

Also in the sixties, Boris Levinson, a child psychologist, used companion animals as part of a diagnostic and therapeutic technique. He also surveyed his colleagues and found that most either used animals therapeutically or recommended pets to their outpatients. In addition, the majority felt that animals could be used to treat adjustment problems of children and adolescents.

Approximately a decade later, Samuel and Elizabeth Corson conducted studies in a psychiatric institutional set-

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ting where individual animals, mostly dogs, were used on a one-to-one basis with each patient. They reported that although patients in their study had not responded to other types of therapy, e.g., psychotherapy, drugs, electroshock, occupational, recreational, only 6 percent failed to respond to the animal therapy.

Alan Beck and Aaron Katcher have documented the therapeutic benefits of animal companionship:

Patients who are unwilling to approach or talk to a therapist are able to reach out to an animal. After playing with, touching, and talking to the animal, they begin to talk to humans again.

Beck and Katcher reported a number of other findings:

1. Almost everybody with a pet talks to it as if it were a person, and the way people talk to cats, dogs, and birds resembles the way we talk to infants.

2. While talking to people usually raises blood pressure, sometimes to very high levels, the touch-talk dialogue we establish with pets reduces stress and lowers blood pressure.

3. Just having a pet in a room makes people feel safer and lowers blood pressure.

4. People with pets make fewer doctor visits.

5. Pets can coax smiles and words out of socially withdrawn institutionalized patients of all ages.

6. Pets can make psychotherapy progress faster. According to Beck and Katcher, 99 percent of the clients at the University of Pennsylvania veterinary clinic said that they talked to their pets. Over 30 percent said they confided in their pets. Most of the children who talked to their pets believed that the pets understood the meaning of the words they were using. More than 70 percent of adolescents owning horses confided in the horse.

Further, relationships with animals have been shown to have favorable effects on patients with heart disease. A study of heart disease conducted from 1977 to 1979 at the University of Maryland found that pet ownership was one of the best predictors of survival for patients with heart disease.

In a large Australian study of animals and cardiovascular health, Gregory L. R. Jennings, Christopher M. Reid, Irene Christy, et al reported,

Cardiovascular risk factors were examined in 5,741 healthy participants attending a screening service. Pet owners had significantly lower systolic blood pressure and plasma triglycerides than nonowners. There were also significantly lower cholesterol values in men but not in women.

This group also reported on the 1994 Australian People and Pet Survey, which included an actual calculation of money saved through fewer doctor visits, hospitalizations, and use of pharmaceuticals as a result of pet ownership. Obviously, many people feel comfortable and receive benefit from communicating with animals.

Even more important, perhaps, is the emotional effect pets have on humans:

When people face real adversity—disease, unemployment, or the disabilities of age—affection from a pet takes on new meaning. Then the pet's continuing affection is a sign that the essence of the person has not been damaged.

Research showing the health benefits of pet ownership and interaction with animals is voluminous. Others have studied the use of animals in the psychotherapeutic setting and shown that animals can enable patients to communicate more effectively; however, there is a dearth of research in the pastoral care setting. Based upon the findings from other communications-type research, one would expect that animals also would facilitate pastoral care communications in a hospital setting.

The pastoral care dog project

The hypothesis for this study was that an animal, in this case a trained therapy dog named Scruffy, can aid in the chaplain's delivery of pastoral care and can serve as a "bridge" to restore normal human communication when such communication has been disrupted for some reason.

The study involved a team of one chaplain intern and her trained therapy dog working for four months during the chaplain's
fourth unit of Clinical Pastoral Education (CPE). This team is licensed by the Delta Society, the national licensing organization for animal-assisted therapy, to work with patients in most hospital settings as well as in other environments.

Although the team had extensive experience in a hospital setting, they had previously worked in active rehabilitation therapy, e.g., physical, occupational, speech, and always under the direction of a licensed therapist. During the study period, the team visited individual patients when there was an identified need for pastoral care and it was thought that the use of a dog may be beneficial.

During the first week, the concept was presented formally to social workers, case managers, chaplains, and CPE students. Settings where it was thought that the dog may be helpful included situations in which patients demonstrated the following behaviors or conditions:

1. Inability to discuss feelings about some particular subject
2. Limited communication in general, i.e., yes/no responses only
3. A physical impediment to communication
4. A depressed mood
5. Fear or anxiety, especially regarding physical condition or hospital environment
6. Anger toward staff or family members
7. Coma

Staff members were invited to make referrals at any time by calling a designated digital pager number. The patient was visited as soon as possible following referral, generally within one hour. During the visit, the dog was used in whatever manner was deemed appropriate by the chaplain/handler.

Visits were made only when the dog was completely clean, healthy, comfortable, and happy. No visits were made to patients with open wounds. Standard precautions were incorporated for all visits as follows:

1. Thorough hand washing by the chaplain/handler before and after each visit
2. Application of dander remover to the dog immediately before visiting
3. Application of a light coat of hand-sanitizing gel to the dog between visits
4. Use of draw sheets or other hospital linens to cover any area where the dog was placed, e.g., patient's bed or bedside chair
5. Immediate removal of used linens after the visit and their placement in laundry hampers

Additional precautions were taken within the Intensive Care Unit (ICU). Prior to the visit, the patient's nurse indicated the location of all IV lines and catheters to the chaplain/handler. After the visit, the nurse washed any part of the patient which had come in contact with the dog.

Each visit was documented in the following manner:

1. Date and number of the visit, e.g., first, second, third
2. Patient's referral category, e.g., depressed mood, anger, communication problem, coma
3. Anecdotal description of the visit, written by the chaplain, which included observations by other professionals, e.g., physicians, nurses, chaplains, social workers

At the end of the study period, patient records were grouped two ways: by number of visits, to determine whether the number of visits affected the outcome, and by referral category, to determine whether any particular type of patient was more likely to respond to the "dog as bridge" hypothesis.

**Study observations**

Twenty-three patients and four family members were visited during this study. A total of seventy-five visits were made to patients, with each patient receiving from one to seven visits. None of the visits was found to affect a patient's communication with others in a negative way.

Although the overall assessments were subjective, with one exception, the eleven patients who were visited two or more times showed increasingly positive responses to the pastoral care dog. The exact number of visits did not appear to be a factor.

Of the three patients who were referred for highly physical reasons (two for coma and one for a physical impediment to communication), no change was noted after the initial visit.
Observers did note positive changes on succeeding visits.

The four family members appeared to benefit as much as the patients and should be considered appropriate recipients for this kind of care.

Many patients enjoyed reminiscing about their own pets as they stroked Scruffy and talked to her. Several who had not been cooperative with physical/occupational therapy prior to visits from the pastoral care dog returned to active participation in the exercises.

Further anecdotal observations

Case 1

While Mr. J was in the hospital to have his shoulder repaired, his wife died unexpectedly. He refused to discuss her death with family members or staff. They had had a long happy marriage, and their three children were grown and married.

When the children tried to talk about their mother and her death, Mr. J informed them that he did not want them to wait until his discharge for the funeral arrangements and burial, and said that he would discuss nothing more about her. He refused to reminisce, to express any emotion, or to allow those around him to express their emotions. He insisted, “I refuse to deal with any of that now. I will handle it when I get home. Now talk about something else.”

The children were very frustrated with him—saying that this just wasn’t like him, that he normally shared his feelings rather freely. Hospital chaplains as well as the family’s religious leaders and a psychologist all visited with Mr. J. In each of these cases, his response was the same as it had been with his children. It was simply not a topic for conversation. He was always very pleasant and very willing to discuss any subject except his wife or death in general. “I’ll deal with that when I get home!” was his only response.

Knowing that he owned a dog, we decided to try our Pastoral Care Dog, Scruffy. Arriving at his door, I said, “Mr. J, I thought you might like to see my dog.” He responded, “Ah, poochie, come here to Papa!” Almost immediately, he became totally focused on Scruffy, seemingly unaware of my presence even though I sat on a chair about two feet to his side and in front of him. He began by telling Scruffy about his own dog and then progressed to stories about things he and his wife had done with their dog.

Soon he was telling Scruffy about his wife, the things they had done together, and how very much she meant to him. As he talked to Scruffy, she responded appropriately by resting her head on his leg, looking up at him, licking his hand, and nuzzling into the crook of his arm. The conversation had taken nearly an hour by this point. He had laughed, cried, and smiled. Scruffy seemed to be feeling with him.

Then he said, “That’s why I have to do it, old boy. I just can’t go on without her.” At this, Scruffy pulled away from him and gave him what appeared to be a very disapproving look. He reached for her, but she wouldn’t budge. Finally, he softened and said, “You’re right, old boy. I can’t do it. Anyway, if I did, she’d make heaven a living hell for me. I’ve got to stick around down here for a while more. It’s just not my time yet.” As he said this, Scruffy nuzzled back into his lap. He went on to tell her about the things he was going to do with his grandchildren, planning a fishing trip with them as he talked about how much they still needed him and of his influence on them. Occasionally, he chuckled and said that his wife really would approve of all these things.

After another half hour, he seemed startled, and even frightened, as he said, “But I can’t go on and do these things without you, old boy!” Finally, I spoke, and he seemed shocked that he was not alone with Scruffy. I reminded him that his own dog waited for him at home, and that this dog knew and loved his wife so he should be an even better listener than Scruffy had been. After all, Scruffy had never had the opportunity to meet his wife. He laughed and agreed, thanking me and hugging Scruffy.

The pastoral care nurse who followed Mr. J after his discharge reported that he appeared to be dealing with his grief appropriately. As for Scruffy, this visit left her exhausted. She fell asleep in the car before we got home. Then at home she slept soundly for more than five hours. This kind of “work” is hard on a dog, and a significant recovery period is necessary to avoid burnout.
Case 2

Mr. S's condition was described as terminal. He was in a coma and totally unresponsive to any stimuli. His wife desperately wanted to talk with him before he died. She also said that he always had loved dogs deeply. With her encouragement, we decided to have Scruffy visit him.

I positioned Scruffy at his bedside. Mrs. S took her husband's limp hand and placed it on Scruffy's back. Then with her hand on top of his, she began moving his fingers through Scruffy's fur. She continued these motions for about five minutes and then left his hand resting on Scruffy's back.

As she and I began to talk, we noticed that Mr. S was moving his fingers by himself. He began to pet Scruffy, and then, using his own strength, he turned on his side and started stroking her with both hands. He opened his eyes, and said, "A dog." Then he looked up at his wife and said, "Jane, I love you." She responded to her husband, and they began having a real conversation. As his focus shifted to his wife, I quietly left with Scruffy.

Mr. S subsequently died as expected, and it is my hope that this final conversation brought peace both to him and to his wife. In this case, Scruffy's extensive training probably made little difference. Any dog that would stand still for an extended period probably would have had the same success.

Case 3

Scruffy and I stayed with one man while life support was withdrawn from his wife. Although the rest of the family wanted to be with her when she died, he said that he could not. While stroking Scruffy's fur, he said, "I never could survive this terrible time if you weren't here with me." Then he sobbed and hugged her.

Case 4

A patient's daughter stopped me in the cafeteria to say, "Mom is in bad shape. I know the only thing that will help her right now is to see Scruffy again!" (We visited immediately.)

Case 5

A woman who had been on life support in the ICU for months admitted that Scruffy was her only reason for living. The Ethics Committee decided that Scruffy was a comfort measure for this woman and that her support should be continued.

Case 6

An ICU physician taking a patient's vital signs as I placed Scruffy on the bed apparently noted a beneficial effect on the patient's heart rate. "I want that dog in bed with my patient every day," he said.

Conclusions

The information gathered through this study supports the hypothesis that the "pastoral care dog" can serve as a communication bridge for people when normal communication has been disrupted. In validating previous research that animals have a generally therapeutic effect, it makes the case for their use in pastoral care.

Additional benefits of Scruffy's presence included the following:

1. The patient's family members and visitors expressed appreciation and seemed comforted.
2. Informal visits with those in the hospital waiting rooms provided distraction as well as soothing comfort.
3. Employee morale appeared to be greatly improved when the dog was in the area. They seemed more understanding of each other and more available to respond happily to patient needs. "Come over here. I need my doggie fix for the day," was often heard.

Although quantifiably significant data were not obtained, the project was deemed a success, and it was decided to utilize the pastoral care dog on a permanent basis. It is the author's hope—and prayer—that other hospitals across the country will adopt this type of program, and she is willing to assist them in that process.

Criteria for a successful program

The following ingredients contribute to a successful Pastoral Care Dog Program:

1. A chaplain experienced both in providing quality pastoral care and in handling the animal
2. A well-trained dog, one with experience as a therapy animal
3. A facility that understands the value of animals in a health care setting

Probably the easiest and least expensive way to acquire these
"ingredients" is to start with a professional chaplain who has a well loved, obedient dog as a pet and to have them go through obedience training. A formal "team evaluation" by the Delta Society to determine whether the team of chaplain/handler and dog has the skills and aptitude for animal therapy work is the next logical step. Salt Lake Theological Seminary offers a course, titled "Christian Ministry and Animal Assisted Therapy," which provides both the theological background and the practical animal related skills needed, followed by the formal Delta evaluation administered through Intermountain Therapy Animals.

Following a successful evaluation, the chaplain completes an eight-hour workshop and written test. Finally all this paperwork, together with results of a careful veterinarian examination, a photo of the team, and a membership fee are sent to Delta Society. When the process is completed and an identification badge returned, the team has the professional responsibility of meeting nationally accepted standards and also is covered under Delta's one million dollar liability insurance. Often institutions are most interested in the latter.

In addition to this national affiliation, the author also recommends becoming involved with a local animal assisted therapy organization. The Delta Society can be helpful in locating such groups. The local organization, in turn, can be very useful in providing the chaplain/handler with a supportive network to keep animal-handling skills current. In addition, they help to ensure that the animals are treated well, rather than regarded merely as tools, and advocate for the therapeutic utilization of animals in new facilities.

References
4 Ibid., 7.
5 Ibid., 14.
6 Ibid., 3-5.
8 Ibid., 169.

Additional Bibliography