Journal of Veterinary Behavior (2007) 2, 15-22

ELSEVIER

Journal of
Veterinary Behavior
Clinical Applications
and Research

REVIEW

A look at the role of marriage and family therapy skills within the context of animal behavior therapy

Janet Canino, PhD, LMFT, Julie Shaw, RVT, Alan M. Beck, ScD

Purdue University, West Lafayette, Indiana.

KEYWORDS:
animal behavior;
veterinary behavior team;
veterinary technician;
marriage and family therapy;
emotionally focused therapy (EFT);
counterconditioning;
interviewing skills;
client communication

Given that veterinary care involves both animal patients and human clients, it becomes necessary to find ways to improve not only one's veterinary medical skills, but also one's interpersonal abilities. Literature that discusses the communication and interpersonal aspects of veterinary medicine is neither widely available nor current; therefore, this article draws parallels from the systemic field of marriage and family therapy (particularly, emotionally focused therapy) to provide updated recommendations to improve the professional relationship between the veterinary behavior team and their human clients. An introduction with background information about the veterinary behavior team and of marriage and family therapists is included. Additionally, the similarities between the 2 fields regarding the mechanisms of the change process (i.e., of creating positive associations), the methodology of obtaining information from clients, the challenges and barriers with human clientele, and the common presenting problems are examined, with examples from both fields provided.
© 2007 Elsevier Inc. All rights reserved.

How the veterinary behavior team can benefit from borrowing skills in the field of marriage and family therapy

Although animals are clearly the central focus of most veterinarians and veterinary technicians, most patients are generally accompanied in the exam room by their owners. Thus, not only are one's clinical skills important, but so are one's interpersonal proficiencies. From a financial standpoint, the interpersonal skills of the veterinary staff are crucial, since client satisfaction has been linked with veterinarians' personalities (i.e., likeability) and to their ability to communicate effectively (McCurnin, 1988). Unfortunately, there appears to be a lack of research that delineates how professionals in the veterinary field can achieve competence in communicating with their human clients (Lane, 2003). The relatively little information on the topic that exists, such as one article by Carole Fundin (1991), is in dire need of being updated.

This article is primarily a product of direct observations of animal behavior sessions at Purdue University's Animal Behavior Clinic. The article discusses both the commonalities and the differences between the counseling aspects of animal behavior therapy and the field of marriage and family therapy. Most importantly, since the animal behavior team (veterinarian and veterinary technician) needs to maintain a strong alliance with the animals' owners, some recommendations from the marriage and family therapy field for improving the human side of the professional relationship are included.

The role of the veterinary behavior team

A veterinary behavior team includes both a veterinarian and a credentialed, licensed veterinary technician. The veterinarian's role includes ruling out both primary and secondary health issues, diagnosing behavior problems, prescribing

Address reprint requests and correspondence: Julie Shaw, RVT, Purdue University, VCS/Lynn, 625 Harrison Street, West Lafayette, IN 47907, Tel: (765) 494-8154.
E-mail: shawjk@purdue.edu

1558-7878/$ -see front matter © 2007 Elsevier Inc. All rights reserved.
doi:10.1016/j.jveb.2006.12.005

medication, prescribing the behavior modification treatment plan, and determining a prognosis for the behavior problem. History taking; general client communication; problem prevention techniques; addressing lack of training issues; assisting the client in understanding and applying behavior modification techniques; and after-care follow-up contacts are generally the responsibility of the veterinary technician, although any change in the prescribed treatment plan remains the veterinarian's responsibility.

The marriage and family therapy perspective

Marriage and family therapists (MFT) are a group of mental health professionals trained and licensed to diagnose and treat mental and emotional disorders within the context of marriage, couples, and family relationships (AAMFT, 2002a). Some of the common presenting problems MFTs encounter include depression, anxiety, and child behavior concerns (AAMFT, 2002b). Marriage and family therapists differ from other counselors and psychologists in that the focus is on effective communication and problem solving (Watzlawick, 1978) within a framework of general systems theory (von Bertalanffy, 1968).

The systemic way of thinking is particularly important to MFTs. According to the American Association for Marriage and Family Therapy (AAMFT, 2002a), "the unit of treatment isn't just the person—even if only a single person is interviewed—it is the set of relationships in which the person is imbedded." In other words, MFTs try to include all relevant family members in therapy even if it appears to be an individual problem, such as anxiety. This idea is based on the assumption that even an individual type of problem has an effect on other people central to the client's life, which means the problems individuals face extend beyond the individuals themselves (AAMFT, 2002b).

For example, a female client who suffers from posttraumatic stress disorder (PTSD), a specific type of anxiety disorder, could likely cause changes in her marriage and with her children as a result of the PTSD. Specifically, because of the flashbacks and nightmares she has, her husband may not sleep well at night. Even though he is worried about her, the husband might start to become angry with his wife for disrupting his routine. In this case, her anxiety problem clearly has effects that reach beyond the individual client.

The first author (JC) uses emotionally focused therapy (EFT), specifically, with her clients to guide them in interacting in more effective ways, thereby facilitating the repair of distressed relationships. EFT is a comprehensive theory of romantic attachment that considers relationship stress to be the result of perceived threats to basic adult needs for safety, security, and closeness in intimate relationships (The EFT Zone, 2006). As Sue Johnson, the developer of EFT (1996, p. 62) states, "Change in EFT comes not from a reprocessing of inner emotional experiences, but from new dialogues that arise as a result of this experience." This statement means that new, positive emotional associations about the relationship are formed, which allows the spouses to respond differently to their partners, in turn alleviating much of the previous relationship distress.

An analogous philosophy is embraced by the veterinary behavior team. In this setting counter-conditioning, via classical conditioning, is the preferred method of creating positive associations where distress had previously existed. The goal is to replace the fear reaction with a more positive emotional response. This philosophy will be discussed in greater detail in a later section.

How MFT relates to veterinary behavior therapy

Four major parallels can be drawn between these 2 seemingly divergent fields: (1) how therapeutic change occurs, (2) the methods for obtaining information from clients, (3) the difficulties and barriers encountered with clients, and (4) the presenting problems brought into therapy. These 4 areas will be explored in greater depth, and examples from both marriage and family therapy and animal behavior therapy will be provided.

How therapeutic change occurs

One of the most striking similarities between the work of the animal behavior team and emotionally focused marriage and family therapists involves how change occurs in each context of treatment. More specifically, it seems that both professions seek to change the emotional experience of the clients. Couples, for instance, often find themselves in a destructive interaction cycle that repeats itself in times of stress. In this case, the content about the problem is irrelevant, as the pattern is the same whether they are talking about who does more of the household chores or if they are having a dispute about their sex life. The emotionally focused therapist works at changing the emotional responses of each person by restructuring how they interact with one another.

An example of this situation can be seen with regard to Dan and Jackie, a married couple with 2 young boys. With his wife, Dan would often "withdraw into his shell." Although Jackie could tell Dan was upset about something, she never knew what the problem was, as Dan was more likely to disclose his feelings to one of his friends rather than to his wife. While talking about situations that lead Dan to withdraw, it was discovered that he was afraid of hurting his wife by failing to live up to her expectations. In other words, he found it "safer" to withdraw and not to give her any response at all than to risk saying the wrong thing and inadvertently escalating the behavior.

Dan: I'm too afraid of hurting her. I don't think I meet her expectations, so it's just safer if I don't say anything at all.

Janet: Can you tell her that? Can you let her know that you really do want to let her in, but that you're too worried about disappointing her? Can you say that to her right now?

Dan: Jackie, I want to be able to share with you what I'm going through, but I'm scared you're going to think less of me for what I feel. I'm worried you don't think I'm good enough.

Janet: Dan, you did a good job of letting Jackie in by telling her some of your fears. Jackie, on the one hand, you want Dan to share his fears with you and to be let in. On the other hand, there's probably a part of you that worries if he can continue to do this or if it was a one-time deal.

Jackie: Yeah, it felt really good to hear what he had to say. I felt closer to him because of it. And I need that closeness. [Turning to Dan] But, yeah, I'm worried that you won't feel comfortable enough to do this again and we'll be so distant like we were before.

Keeping in mind that the goal of EFT is to change the "emotional field so that individuals and interactions are reorganized to result in more functional relationships" (Greenberg & Johnson, 1986), one can see how the "emotional field" of this couple changes even within this brief dialogue. Instead of allowing the husband to act in his typical way (i.e., to withdraw), the therapist draws him out and touches on his concerns about "not being good enough for his wife." Validating his fears prevents his wife from taking a verbally defensive position and allows her to truly hear what her husband is saying. The wife, in turn, reacts to his revelation about his inadequacy in a new and positive manner; she does not yell at him nor roll her eyes, as he has grown accustomed to her doing when he starts to talk to her. In contrast, she listened quietly and she now feels closer to him because he refused to withdraw from the conversation and instead took a risk and shared his fears with her.

Being able to articulate these risky emotions (e.g., fear, hurt) changed the couple's interactional cycle from one that disintegrated into criticism and blame and replaced the old, ineffective cycle with one that was more positive in tone and in content, as well as more effective in creating intimacy and closeness. Thus, their association to each other and to their relationship shifted from highly stressful and negative in nature to one of positive associations about sensitive responsiveness and emotional security (Johnson, 1996).

Likewise, the veterinary behavior team often attempts to change the "emotional" response of the client, as well as the animal. In this case, by emotional response, it is not only the dog's fearful or aggressive reaction to a stimulus that they seek to change, but also the fear- or anxiety-laden behavior of the owners. Owners often react to their dog's fearful or aggressive behavior in ways that inadvertently reinforce or increase their dogs' fear. For example, owners may anticipate an aggressive outburst from their pet, become anxious themselves and thus, grip the leash tighter, while at the same time they are unconsciously changing their breathing patterns (i.e., holding their breath or breathing rapidly). All of these anxiety-induced behavioral changes in the people are frequently and inadvertently conveyed to the dog.

The veterinary behavior team relies on counterconditioning to create an emotional change in both the patient and the owner. Counterconditioning addresses the relearning process that occurs by eliciting a new emotional response in the presence of a particular stimulus (Davison & Neale, 1998). In general, counterconditioning is intended to change a negative emotional response to a stimulus (e.g., particular person, specific sound) to a positive emotional response. Counterconditioning principles underlie one of the most commonly used behavior therapy techniques—systematic desensitization (Davison and Neale, 1998). This technique works in incremental stages to induce a sense of relaxation around the original feared stimulus (Wolpe, 1958), since relaxation and fear are incompatible behaviors.

Consider the example of Toby, a Pomeranian, who in a previous visit to the veterinarian's office had the unfortunate experience of having a boisterous Great Dane inadvertently step on him in the waiting room. Although Toby sustained no physical injuries in the incident, the experience left Toby terrified, as evidenced by the trembling and drooling that starts to occur as soon as he sees the veterinary clinic. At the same time, the owner grips onto Toby's leash in anticipation that he will try to bolt. A noticeable anxiousness in the person's voice can also be detected as he tries to calm his dog. Clearly, receiving routine medical care has become extremely stressful for both Toby and his human family members.

His treatment at the animal behavior clinic is simple, but effective. In this case, the feared stimulus is the veterinary hospital. His emotional response to going to the clinic needs to be changed from being fearful to pleasant (or at least tolerable). By giving him his favorite treat, pieces of cooked chicken, in combination with the owner's upbeat and cheerful verbal signals, Toby is reinforced for any nonfearful response. Since the greatest fear is shown about 15 feet before the clinic door, the owners will back up to about 20-25 feet away from the doorway, as it is necessary to start in a nonfearful state, and then reward Toby for taking even one small step toward the door. The restructuring of the negative (i.e., fearful) associations has begun at the point where Toby is reinforced for moving closer to the feared stimulus (the hospital reception area). His treatment will be continued in tiny increments until Toby can willingly walk into the animal behavior clinic with no other potentially frightening patients present and show no signs of fear (e.g., no shaking or drooling). Once inside the clinic, the veterinary staff will also reward Toby with cheese cubes, another of his favorite treats. This reinforcement serves as an additional way to create positive associations with the veterinary clinic. Eventually other characteristics such as including a small, calm dog in the waiting room on Toby's entrance will be added.

Through the process of counterconditioning and desensitization, Toby learns to associate the veterinary reception

area and the veterinary staff with pleasurable things, in this case chicken, cheese, and positive verbal communication from the owner. His fear that stemmed from an unpleasant experience in the veterinary hospital waiting room, in essence, will be replaced by expectations of tasty food treats. At the same time, the owners have now been given the tools to change Toby's emotional response. As the owners see progress in Toby's response, their emotional response also changes from that of anxiety to confidence.

Therefore, in each field the goal of these sessions is to change the emotional responses to the stressful situation into a more positive emotional response for both the owners and, in the case of the veterinary team, of the dog, as well. Of course, the means to promote the change will take on different forms in each profession, such as via restructuring ineffective interactions in marriage and family therapy. In contrast, in the field of animal behavior, the mechanism of change is through counterconditioning and desensitization of the dog, along with clear communication to the dog's owners about what is happening and how their own behaviors and emotions may play into the fear cycle. Nevertheless, the result, which is to reduce stress in the patients (animals) and clients (people) and create positive changes in their emotional responses, is similar.

Obtaining information from clients

Another interesting similarity is how closely the assessment/intake portion of the therapy session at the animal behavior clinic resembled the intake process at the Purdue University Individual, Couple, and Family Therapy Center (PICFTC). With the animal behavior session, the assessment, conducted by the veterinarian and veterinary technician, is quite lengthy. An extremely detailed history, often including video of the specific behavior, can take between 60 and 90 minutes.

Time is also spent gathering information on significant change events. Inquiring about change events is one way of assessing the extent to which clients (people) and patients (animals) may be in crisis (Patterson et al., 1998). A specific recent event may have prompted the call for an appointment. For a dog and his family, it may have been the birth of a baby or a sudden aggressive attitude toward the owners. For couples, the change event could also have been the arrival of a baby or perhaps the loss of a job. Regardless, it is important to find out if they are acute or chronic problems and when these events first occurred (Patterson et al., 1998). Knowledge about these stressors provides valuable information in both human and animal therapy settings. Specifically, information can help pinpoint whether the stress is underlying the presenting problem or is only a symptom of it.

Furthermore, assessment information is also gathered from as many people as possible in both types of therapy sessions. The systemic approach in marriage and family therapy was previously mentioned. Similarly, for related reasons, veterinary animal behaviorists often request that as many family members as possible attend the session. Again, this idea is predicated on the belief that all people in the family system are affected by the problem, regardless of how individual in nature the problem may seem (AAMFT, 2002b). Another reason for the systemic approach centers on the attitude of "Here. Fix my dog/kid." In family therapy, for instance, a father may bring in his daughter because she is being truant. The father finds it difficult to see why he would need therapy when "the problem is about *her*, not me." Having the father in the room, though, may later reveal that he believes he is incompetent as a parent. As a result, he tries to avoid interacting with his daughter because of these thoughts. His daughter has been attuned to his withdrawal and internalizes it as rejection by her father and skips classes as a way of managing this rejection. Thus, one can see how important it is to have more than the identified patient in therapy.

Identical attitudes are seen in the animal behavior clinic. Often a distraught owner walks in expecting the therapeutic team to work with the dog and return him "fixed." The owner, in general, fails to recognize how she has contributed to the problem. For instance, a woman brings in her 3-year-old poodle. She made the appointment because she wanted him "cured of his jumping problem." During the assessment phase, she was asked about how she responds when he jumps on people. At one point she declares, "I don't know why you keep asking me all these questions. *He's* the one who needs to be fixed!" Later she reported that when he jumps up, she pushes him off and tells him, "No." Unbeknownst to the owner, she was indeed a part of the problem. Every time she pushed the dog down and gave him verbal corrections (i.e., "No") the dog was being rewarded with attention. Clearly, the woman had strengthened the unwanted behavior and consequently needed to be a part of the solution. Furthermore, this story emphasizes the need to think systemically in nature (that all family members are affected by the problem) (Dehasse, 2002) as soon as the initial phone contact occurs. Otherwise, the problem is likely to have a poor prognosis since, as seen in the previous example, integral pieces of the solution would be missing

Difficulties and barriers in therapy: 1. Establishing credibility

Since MFTs and veterinary behavior teams both work with human clients, it makes sense that each therapist might encounter similar difficulties in their sessions. Two problem areas, establishing credibility and clients' fears regarding the therapeutic experience, are seen in both types of clinical settings.

One of the first objectives in marriage and family therapy should be to join with the clients, which means establishing a strong alliance with the clients in the session. An alliance represents the interactive and bidirectional relationship between the therapist and the clients (Rigazio-DiGilio, 2002).

A critical element to joining is dependent on the client viewing the therapist as credible and trustworthy. For clients to be able to have hope that change is possible, they must believe in the process, because without hope they may terminate prematurely (Patterson et al., 1998).

Likewise, the veterinary behavior team needs to make an effort to join with their human clients in order to engender hope in them, as well. Moreover, pet owners who do not trust their veterinary behavior team may become noncompliant. Sometimes therapists may lose credibility, in the client's eyes, if they have not personally dealt with the problem, such as a family therapist who has no children and is being asked to deal with a rebellious adolescent. Another example of this situation could be a veterinary behavior team that fails to gain the client's trust if he or she has never owned a dog that was aggressive toward toddlers or is unfamiliar with the behavior of toddlers, when that is the client's presenting problem.

A veterinarian is likely to be the first professional the client contacts when his or her pet has a behavior problem. The veterinarian and veterinary technician can quickly develop a relationship with the client by letting the client know that the issues being faced are not uncommon and that, in most cases, treatment options are available. This is often a primary role for the veterinary technician. The technician can communicate with the owner through follow-up phone calls and e-mail to clarify the treatment plan and to assist with problems the owner may be having in implementing the treatment plan. Emotional support can be given by empathizing with the owner if progress has been minimal or by providing positive reinforcement to the owner for any progress that has been achieved. A primary benefit of taking the time to join with the client is that the veterinary behavior team can develop a rapport with the client, which will be invaluable during the administration of the treatment plan and in the eventual follow-up care.

When joining is not immediately successful and trust and credibility seem to be at stake, several strategies exist to improve the situation. One option is to redefine what type of experience is needed to be successful (Patterson et al., 1998). Specifically, through follow-up communication with the client, via phone or e-mail contact, the veterinary behavior team can discuss how each aggressive dog is a unique situation, and even though the presenting problem may be familiar to the behavior team, other factors might be different. A reassuring analogy to mention would be that 2 people diagnosed with skin cancer are likely to react in a dissimilar manner to the distressing news, despite the same diagnosis. Therefore, it is not necessary for each professional to have had similar experience in the area of the presenting problem.

Moreover, normalizing the problem may improve the therapeutic alliance. Normalizing includes helping clients to see that this is a problem that other people have, as well (Ivey and Ivey, 1999). Clients often become more hopeful and trusting by knowing that others have had similar struggles and have been successful at resolving them. Caution, however, must be used in not minimizing serious problems (Ivey and Ivey, 1999), such as a dog that has bitten a child or a puppy's extreme case of separation anxiety. The point of normalizing is to remind clients that everyone has some areas they struggle with and that there is hope that the situation can change for the better.

Difficulties and barriers in therapy: 2. Fears surrounding therapy

In general, clients enter a therapy room with some level of anxiety about the process they are about to undertake. In human behavior, anxiety frequently manifests itself in the form of either reluctance or resistance (Egan, 2002). Reluctance means that clients are hesitant to behave or interact differently, as recommended by the therapist (Egan, 2002). Creating change involves significant effort on the part of the client and includes asking the client to take a risk into unfamiliar territory. It can be particularly scary for clients to do things differently, so sometimes they hang back, unsure if and how they should proceed. Often it is at this point that the veterinary technician's assistance can be critical for the positive outcome of the case by instructing the owner not only as to how he or she can successfully implement the veterinarian's prescribed treatment plan into their daily lives, but also ensure that the owner understands specifically how the prescribed techniques will modify the pet's behavior.

Clients are often reluctant to comply with the treatment plan for several reasons, including shame, a lack of trust, or fear of change (Egan, 2002). For example, clients may not trust the person who is trying to help them. This mistrust could be because clients feel like they are surrendering control to someone unfamiliar to them. Additionally, clients may worry that the treatment team will judge them. Specifically, in marriage and family therapy, clients may find it difficult to share that they have been physically abused because they are ashamed of their past and they fear that the other person will perceive them as somehow deserving of the abuse. Pet owners, in contrast, may be concerned that they will be blamed for their dogs' aggressive behavior and subsequently labeled as "bad owners." Understandably, clients are reluctant to share their inadequacies and their flaws because they are embarrassed or ashamed of them. They want the professionals, moreover, to see them in the best possible light, which sometimes means that the facts are distorted or exaggerated, or they are withheld altogether. For others it is the fear of changing that may contribute to their reluctance in complying with the proposed treatment plan. Frequently, clients have been living with or managing the presenting problem for so long that they are doubtful change is possible. Furthermore, agreeing to change involves extra effort on their part, which the clients may see as a higher cost than the reward the change will provide.

Resistance, on the other hand, occurs when clients feel coerced (Egan, 2002). For the client, it is their way of trying to regain control of the situation. One may experience resistance when clients continually disagree and protest, show no effort to implement the therapeutic recommendations, or terminate treatment prematurely (Egan, 2002). This result can occur if the veterinary behavior team places guilt or blame on the client or implies that the owner is the sole cause of the problem (Hetts, 1999). Clients who are resistant seem to be those who feel they are not entering into the therapeutic process voluntarily.

For instance, marriage and family therapists may be asked to see an adolescent who has had multiple suicide attempts, but the adolescent may be required by her parents to enter therapy. Involuntary participation at an animal behavior clinic can also occur. An example might include the case of a cat that regularly refuses to use the litter box. A girlfriend may give her live-in boyfriend an ultimatum, such as either fix the problem with his cat or she will move out. This situation, too, can create a feeling of coercion at the onset of treatment.

Reluctance and resistance should be explored with clients to find out what underlies it. Working collaboratively on the treatment goals may give clients a greater sense of control, thereby fostering a safe climate within which to change. In addition, it is helpful to let clients know that their fears and concerns are normal and to be expected. Sometimes this assurance is all clients need in order to start the change process.

Problems brought into therapy: Similar presenting problems

Anxiety, abuse (e.g., physical violence), and behavior problems are the 3 prominent problems that seem to cut across the field of animal behavior and marriage and family therapy (Munro, 2001). Marriage and family therapists, in particular, report that anxiety, abuse, and child behavior problems are among the 5 most commonly seen problems in the therapy room (Northey, 2002).

Clearly, the problems present themselves in different ways, but both professions are likely to see some examples of these issues on any given day in their practices. Both fields, for instance, may treat a patient who has generalized anxiety disorder, yet also see another patient that experiences high anxiety only in certain situations, such as the case of the human patient who experiences anxiety only when she sees pictures of a snake.

Animal patients can have similar anxiety that may surface in a particular context, such as at the veterinary hospital, or around a specific person or object, such as the vacuum cleaner. Human and animal clients, alike, can lower their anxiety to a particular stimulus through counterconditioning (i.e., systematic desensitization). In addition, both types of clients may be prescribed anti-anxiety medications (e.g., Valium [diazepam] or Xanax [alprazolam]) in concert with psychotherapy or behavior modification.

Secondly, abuse, especially physical abuse, is often seen in therapy. Furthermore, the connection between domestic violence and animal abuse has been strongly supported in the research literature (Lockwood, 2003). For instance, Deviney, Dicker, and Lockwood (1983) surveyed 53 pet-owning families who also met the state criteria for child abuse or neglect. In the cases involving physical child abuse, it was found that 88% of the pets were also abused or neglected.

Frequently such abuse of pets or families goes undetected. Marriage and family therapists, for example, may be working with domestic violence couples and not know it. O'Leary, Vivian, and Malone (1992) found that as many as 67% of clients have experienced domestic violence. Consequently, it may also be true then that, unknowingly, veterinary behavior teams are working with clients (human and animal) who are somehow involved in physical abuse.

One important difference exists between suspected child abuse and suspected cases of animal cruelty. The American Veterinary Medical Association (AVMA) takes the position that when cases of animal cruelty are observed, it is the responsibility of the veterinarian to report the case to the appropriate authorities (Lockwood, 2003). Nevertheless, only a few states (e.g., Colorado) actually mandate reporting of suspected cases of animal abuse (Lockwood, 2003). In contrast, because of the Child Abuse and Prevention Treatment Act and Adoption Amendments of 1996, all 50 states have some type of mandatory reporting regarding child abuse and child neglect. Eighteen states, including Indiana, currently require any adult, regardless of profession, to report suspected child abuse and neglect to either a law enforcement agency or a child protection agency.

General behavioral problems are the third presenting problem that often shows up in both types of clinical settings. Once again, the "here, fix my kid/dog" is relevant. For instance, family therapists often have parents who say, "My child is out of control; she needs help." Parents see only that the child needs to change her ways. It is the responsibility of the therapist, then, to assist the parents in realizing that the daughter, for example, may be running away because she feels too scared to talk with her parents about her problems. In this case, the therapist must show the parents ways to listen to their child that do not involve always trying to lecture her. This approach helps the daughter to trust her parents and feel safe enough to go to them in times of trouble. Other commonly seen behavior problems include failure to respect others, fighting, bedwetting, and poor academic performance.

The veterinary behavior team, in contrast, is likely to experience behavior problems such as aggression problems, anxiety issues, and so on, as well as "lack of training" issues including excessive jumping and attention-seeking behaviors. Additionally, difficulties with housetraining (i.e., elimination occurring in areas deemed unacceptable) are also

frequently seen behavior problems. The client who tells the veterinary behavior team to "fix my dog's barking problem—now!" is another example of a person who cannot see his or her place in the problem. It is likely that every time the dog barks, the owner pays attention to the dog. Therefore, the solution is usually to have the owners (and everyone else) ignore the dog while the barking occurs, which means not touching the dog or even telling the dog "no." Ignoring the unwanted behavior, especially if accompanied by rewarding desired behaviors, will soon end the unwanted problems (Lindell, 2002). However, it is clear that the dog can only be one part of the solution. Again, the owners need to be assisted in seeing how they inadvertently play into the problem behavior cycle.

In each of these settings, moreover, it is important to ensure that there is not an underlying medical reason for the behavior problem. Parents who complain that their son will not sit still for more than 5 minutes and never finishes his homework should first see a physician to rule out physiological and psychological causes, such as attention deficit hyperactivity disorder. An owner who bemoans that her cat fails to use the litter box should first consult with her veterinarian to make sure no medical conditions, such as urinary or kidney problems, can be detected (Horwitz, 2002).

Therapy techniques that can be used by veterinary behavior teams

Three techniques that are widely used by emotionally focused therapists are *validating, normalizing,* and *interrupting*. These techniques are likely to be useful to both veterinarians and veterinary technicians when interacting with their human clientele.

Validation occurs when the therapist truly understands what the clients are experiencing and gives them permission to feel upset, angry, hurt, and so on. The clients are told that there is nothing wrong, shameful, or irrational about their emotional responses to this situation (Johnson, 1996). A veterinarian or veterinary technician might say, "If I were you, I would also feel like I needed to be continually on guard and worried that Buster might bite me. Based on his past behavior, it makes perfect sense that you would feel that way." Letting clients know that you "get it'—meaning you understand where they are coming from and why they feel the way they do—can quiet otherwise talkative clients. Validation also works well with clients who find it difficult to listen when the veterinarian tries to ask them questions or wants to explain treatment options.

Normalizing is a related technique that was briefly mentioned earlier (Hetts, 1999). Often clients come in to the office believing they are the only ones dealing with this problem. Generally, this is not the case, and the therapist is likely to have seen similar problems with previous clients. As a result, it is important to reassure clients that they are not the only ones dealing with such a problem, if that is indeed true. Sometimes the presenting problem is more of a developmental issue, and informing clients that this is part of normal development can be a relief for the clients to hear. For example, a client worries that the constant chewing by her 12-week-old puppy is a sure sign of a behavioral problem. To normalize her concern, one could respond with, "Chewing at this age is a normal part of puppy behavior. Almost all puppies and their owners deal with this frustrating stage for a while." Of course, it would also behoove the veterinary team to go beyond normalizing the concern and to offer the client solutions on how to prevent or manage the chewing problem.

Sometimes it becomes necessary to interrupt a client's story. Societal standards strongly consider interrupting a person to be rude and unacceptable behavior. Marriage and family therapists, however, are taught that learning to interrupt clients is a critical therapeutic skill (Hetts, 1999). Nevertheless, it is a skill that takes time in order to decrease the guilt associated with using it. One way to make it feel more polite is to say, "I'm sorry, but may I interrupt you for a moment?" or "I'm sorry to interrupt, but I need to ask you a quick question." Usually such statements are perceived as less impolite by both the client and the person making the interruption.

Conclusion

This article examines the unexpected similarities, along with the inherent differences, between a marriage and family therapist and the veterinary behavior team of veterinarians and veterinary technicians. In particular, emotionally focused therapy and counter conditioning were explored to see how emotionally focused family therapists and veterinary behavior teams create change by shifting the emotional experiences associated with a specific situation. Three other parallels between the 2 fields were explored, including the means for obtaining information from clients, challenges and barriers with human clientele, and common presenting problems. Throughout the paper, examples from both the field of marriage and family therapy and the animal behavioral field demonstrate that techniques borrowed from other fields can enhance the practice of veterinary behavioral medicine.

References

American Association for Marriage and Family Therapy (AAMFT). 2002a. FAQs on MFTs. Retrieved August 2006, from the World Wide Web: http://www.aamft.org/faqs/index_nm.asp.

American Association for Marriage and Family Therapy (AAMFT). 2002b. Marriage and family therapists: the family-friendly mental health professionals. Retrieved August 2006, from the World Wide Web: http://www.aamft.org/Press_Room/MFT%20Brochure%207-03.htm.

Child Abuse and Prevention Treatment Act and Adoption Amendments of 1996, U.S. Code Citation: Pub. L. No. 104-235, 42 U.S.C. 5101, *et seq.* 1996.

Davison, G., Neale, J. (Eds.), 1998. Abnormal Psychology, 7th ed. John Wiley & Sons, New York, p. 44.

Dehasse, J., 2002. The role of the family in behavioural therapy. In: Horwitz, D., Mills, D., Heath, S. (Eds.), The BSAVA Manual of Canine and Feline Behavioural Medicine. British Small Animal Veterinary Association, Gloucester, England, pp.30-36.

Deviney, E., Dicker, J., Lockwood, R., 1983. The care of pets within child abusing families. Int. J. Study Anim. Probl. 4, 321-329.

EFT Zone, The. 2006. About emotionally focused therapy (EFT). Retrieved August 2006, from the World Wide Web: http://www.theeftzone.com/info/abouteft.htm.

Egan, G., 2002. The Skilled Helper: A Problem-management and Opportunity-development Approach to Helping, 7th ed. Pacific Brooks/Cole, Pacific Grove, CA.

Fundin, C.E., 1991. Basic skills for successful client relations. Probl. Vet. Med. 3(1), 7-19.

Greenberg, L., Johnson, S., 1988. Emotionally Focused Therapy for Couples. Guilford Press, New York, pp. 41–428.

Hetts, S., 1999. Pet behavior protocols: what to say, what to do, when to refer. AAHA Press, Lakewood, CO. pp. 19–22.

Horwitz, D., 2002. House soiling by cats. In: Horwitz, D., Mills, D., Heath, S., (Eds.), The BSAVA Manual of Canine and Feline Behavioural Medicine. British Small Animal Veterinary Association, Gloucester, England, pp. 97-108.

Ivey, A., Ivey, M., 1999. Intentional Interviewing & Counseling: Facilitating Client Development in a Multicultural Society. Brooks/Cole, Pacific Grove, CA, p. 370.

Johnson, S., 1996. The Practice of Emotionally Focused Marital Therapy. Brunner/Mazel, New York, pp. 2–15, 44–45, 62, 70, 86, 95–97.

Lane, J., 2003. Understanding and improving client compliance. Vet. Tec. J. 24(12), 850-853.

Lindell, E., 2002. Control problems in dogs. In: Horwitz, D., Mills, D., Heath, S., (Eds.), The BSAVA Manual of Canine and Feline Behavioural Medicine, British Small Animal Veterinary Association, Gloucester, England, pp. 69–79.

Lockwood, R., 2003. Animal abuse and family violence. the veterinary professional's role in making the connection. Proceedings of the 91st Annual Fall Conference of Veterinarians and Veterinary Technicians, West Lafayette, IN.

McCurnin, D., 1988. Veterinary Practice Management. J.B. Lippincott Company, Philadelphia, PA, pp. 24–36.

Munro, H., 2001. "Battered pets": features that raise suspicion of non-accidental injury. J. Sm. Anim. Pract, 42(6), pp. 218-226.

Northey Jr, W., 2002. Characteristics and clinical practices of marriage and family therapists: a national survey. J. Marital Fam. Ther. 28, 4, 487-494.

O'Leary, K., Vivian, D., Malone, J., 1992. Assessment of physical aggression against women in marriage: the need for multimodal assessment. Behav. Assess. 14(1), 5-14.

Patterson, J., Williams, L., Grauf-Grounds, C., Chamow, L., 1998. Essential skills in family therapy: from the first interview to termination. Guildford Press, New York, pp. 36–68.

Rigazio-DiGilio, S., 2002. Integrative supervision: approaches to tailoring the supervisory process. In: Storm, T., Storm, C. (Eds.), The Complete Systemic Supervisor: Context, Philosophy, and Pragmatics. Authors Choice Press, New York, pp. 195-214.

von Bertalanffy, L., 1968. General System Theory. George Braziller, New York, pp. 1–39.

Watzlawick, P., 1978. The Language of Change. Basic Books, New York, pp. 40–41, 122–137.

Wolpe, J., 1958. Psychotherapy by Reciprocal Inhibition. Stanford University Press, Stanford, CA, pp. 139–165.