ABSTRACT
A grassroots movement of nonprofit, nongovernmental organizations is creating programs in which incarcerated individuals train rescued shelter dogs as therapeutic canines for Veterans with posttraumatic stress disorder (PTSD). Driven in part by reports of Veterans not receiving adequate treatment for PTSD, the programs are the latest iteration of prison-based animal programs and are founded on the principles of animal therapy and healing powers of animals. The far-reaching and deleterious collateral consequences of PTSD create social and economic burdens on the country; providing beneficial interventions for Veterans is a pressing social problem. Without oversight, a patchwork of agencies has developed that provides Veterans with dogs with varying levels of training and differing abilities. To best serve the needs of Veterans, the programs need regulation and standardized methods of training. [Journal of Psychosocial Nursing and Mental Health Services, 54(5), 49-57.]
individuals train rescued shelter dogs as therapeutic canines for Veterans with posttraumatic stress disorder (PTSD). Although prison-based animal programs (PAPs) have become common (Furst, 2006), this new focus on Veterans is a recent development driven by reports of them not receiving adequate treatment for PTSD (Jaffe & O’Keefe, 2014; Reardon, 2013). The numerous collateral consequences of PTSD, including substance use disorders, unemployment, and criminal activity, have led researchers to warn that we are facing a “long-term burden to society of war-related mental health pathology” (Tuerk et al., 2010, p. 54). A unique response to this contemporary social problem comes from a grassroots movement built on the principles of animal therapy and the healing power of animals. Groups throughout the country are bringing dogs inside prisons and jails. Dogs that would otherwise be killed serve a therapeutic role for incarcerated individuals and Veterans.

In the current article, the widespread collateral consequences are considered and the response of the U.S. Department of Veterans Affairs (VA) and barriers to receiving treatment are discussed. Research regarding treatment effects of therapeutic animals is presented and the origins of PAPs are traced. It is within the context of these programs that this next generation of PAPs is described. The current movement by private citizens to provide Veterans dogs trained by incarcerated individuals is examined. Finally, policy recommendations and suggestions for future research are outlined.

LITERATURE REVIEW

Posttraumatic Stress Disorder

Investigations into the prevalence of PTSD among Veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) are based on estimates; the research relies primarily on brief self-report screening assessments often tied to soldiers being processed out of active duty. In such a scenario, issues of confidentiality and underreporting arise (Litz & Schlenger, 2009). The diagnostic tool most frequently used to screen for the disorder has been the 17-item, self-report PTSD Checklist–Military Version (Weathers, Huska, & Keane, 1991). The first study of prevalence found approximately 17% of OIF troops and 11% of OEF troops had PTSD 4 months after returning from deployment (Hoge et al., 2004). A more recent study conducted by researchers from the VA medical center in San Francisco found that more than one third (36.9%) of Veterans returning from Iraq and Afghanistan from 2002-2008 received mental health diagnoses: approximately 22% were diagnosed with PTSD and 18% with depression; the greatest prevalence was among Veterans younger than 25 (Seal et al., 2009).

PTSD is an event-related phenomenon; not every individual who experiences a traumatic event will have the same reaction. More than one half of all adults in the United States report experiencing trauma during their lifetime, but most are not diagnosed with PTSD (Kubiak, 2004). A number of risk factors make some individuals more likely to develop PTSD. Predisposing factors associated with higher rates of PTSD include being younger, female, and a person of color (Phillips, LeandMann, Gumbs, & Smith, 2010). Among military personnel who served in OIF and OEF, those with lower rank, who are unmarried, have less education, and who experienced childhood hardship were more susceptible to PTSD (Smith et al., 2008).

Because proximity and intensity of events are fundamental to developing PTSD (Kubiak, 2004), the nature of Veterans’ experiences in combat are key. As the number of deployments increase, so does the likelihood of PTSD (Hoge et al., 2004; Olusanya, 2012; Polusny et al., 2010). Soldiers who experienced higher levels of combat stress, such as fighting on the front lines, being wounded, and firing weapons, were at greater risk of experiencing PTSD (Hoge et al., 2004; Phillips et al., 2010). Research findings also indicate that killing, having killed, or believing to have killed an enemy during combat is a strong predictor of PTSD (Polusny et al., 2010). In addition, investigators have found perceived military preparedness and sense of personal safety (Kolkow, Spira, Morse, & Grieger, 2007), as well as lower levels of perceived social support, upon return from deployment increase the likelihood of PTSD (Olusanya, 2012; Polusny et al., 2010).

To receive a diagnosis of PTSD from a health care professional, specific criteria must be met. The criteria recently changed with the publication of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association [APA], 2013). PTSD was moved from the class of anxiety disorders to a newly created class, trauma and stressor-related disorders, which requires being exposed to a traumatic or stressful event (APA, 2013). Criteria used to diagnose PTSD in the DSM-5 differ from those used in the fourth edition. Previously, symptoms were divided in three clusters; in the DSM-5, PTSD symptoms are divided into four groups or clusters: (a) intrusion, (b) negative changes in cognition and mood, (c) changes in arousal and reactivity, and (d) avoidance. Intrusion includes re-experiencing the event, having unwanted recurring thoughts or memories (flashbacks) of the traumatic event, and having nightmares connected to the event. Examples of negative changes in cognition or mood are persistent blame, isolation or separation from others, and being unable to remember features of the event. Increased arousal and reactivity symptoms include hypervigilance, aggression, recklessness, self-destructive behavior, and increased startle or fight-or-flight response (VA, 2014). An individual with PTSD learns behaviors or avoidance techniques that prevent triggers that cause negative feelings, thoughts, or moods, including anger, sadness, anxiety, or guilt. Avoidance occurs in response to the other three clusters of symptoms (APA, 2013; Tuerk et al., 2010). It is common for a cycle to develop where a flashback
leads to isolation and hypervigilance, which can reduce anxiety but are also avoidance behaviors that can interfere with treatment and recovery.

**Collateral Consequences of Post-traumatic Stress Disorder.** Researchers describe PTSD as “a particularly deleterious disorder” (Kehle et al., 2011, p. 131), in part due to far-reaching collateral consequences. Combat-related PTSD creates substantial economic and social burdens on the country. Veterans with PTSD are at greater risk for substance abuse, physical health problems (e.g., heart attack, stroke), depression, troubled relationships, and domestic violence (Lee, 2013; Tuerk et al., 2010). Veterans have higher rates of unemployment compared to non-Veterans, as executives in charge of hiring report being “apprehensive about possible mental and behavioral issues” (Goldfarb, 2015, para. 5). Veterans with PTSD are also more likely to be unemployed and require social services. The federal government estimates there are 100,000 homeless Veterans (U.S. Interagency Council on Homelessness, 2010). Perhaps most stark are rates of suicide among Veterans. According to VA’s (2012) statistics, although 1% of Americans are Veterans, they comprise 20% of all suicides in the United States. In sum, the “sheer scale of Veterans in need of mental health services presents a public health problem that is difficult to address fully” (Tuerk et al., 2010, p. 54).

The crisis associated with PTSD is reflected in the number of Veterans becoming involved with the criminal justice system. According to the Bureau of Justice Statistics, in 2011-2012, approximately 181,500 Veterans were incarcerated; they represented 8% of the total prison and jail population in the country (Berzofsky, Bronson, Carson, & Noonan, 2015). Thirty-five states have created Veterans Treatment Courts to address the mental health needs and substance use disorders that frequently lead Veterans to have contact with the criminal justice system (Blomquist, 2014). Veterans are more likely than non-Veterans to be incarcerated for a violent crime (64% versus 52%) and are more likely to be sentenced for a violent sexual offense (35% versus 23%) (Berzofsky et al., 2015). Upon release, these Veterans face the stigma of being formerly incarcerated and will encounter higher rates of unemployment and homelessness, and be at greater risk for mental illness compared to non-incarcerated Veterans (LePage, Lewis, Washington, Davis, & Glasgow, 2013). The relationship between military service, mental health issues, and criminal justice contact is still not completely understood. For example, some individuals argue skills and tactics learned in the military “may translate to aggressiveness, impulsivity, arrest, and potential for incarceration in the civilian community” (Institute for Veteran Policy, 2011, p. 1). Others focus on the role of substance use disorders in increasing the risk of criminal justice involvement (White, Mulvey, Fox, & Choate, 2012).

Following a diagnosis of PTSD, Veterans face several common barriers to care, with the most significant being the stigma associated with receiving mental health care in the military. The nature of PTSD (i.e., avoiding situations and stimuli that may trigger symptoms) means many individuals in need of help will eschew discussing their struggles. As a result, Veterans most in need of help are the least likely to seek it; fewer than one half of those diagnosed with PTSD or depression sought treatment during the first year after returning from overseas (Hoge et al., 2004; Tanielian & Jaycox, 2008). Soldiers who tested positive for a mental health disorder were twice as likely as soldiers who tested negative to report being concerned about the stigma associated with seeking mental health care (Hoge et al., 2004). According to VA research, among a group of approximately 50,000 Veterans with PTSD, only 9.5% received the prescribed amount of help in the year after diagnosis (Seal et al., 2010).

The U.S. Department of Veterans Affairs’ Response to Veterans with Post-traumatic Stress Disorder. The VA has been widely criticized—not only from Veterans trying to navigate the system, but also from Congress and the
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Shinseki resigned in May 2014 amid a scandal; a report by the VA inspector general issued that month found hospital employees conspired to use false patient lists to hide months-long wait times faced by many Veterans (Jaffe & O’Keefe, 2014). A June 2014 report by the Institute of Medicine (IOM) issued a critical assessment of PTSD programs and services provided by the Department of Defense (DoD) and the VA. According to the IOM (2014):

...a lack of standards, reporting, and evaluation significantly compromises DoD and VA efforts. The departments often do not know what treatments patients receive or whether treatments are evidence-based, delivered by trained providers, cost-effective, or successful in improving PTSD symptoms. The departments also collect little information about the effectiveness of their programs in the short or long terms. (p. 4)

In March 2015, newly appointed secretary Robert McDonald announced the creation of an advisory committee that would provide the VA with recommendations on how to institute long-term reform and improve patient care outcomes (Jordan, 2015).

Treatment Effects of Therapeutic Animals

Therapeutic canines offer an alternative to the faltering VA system of services. Animal-assisted interventions (AAIs) include treatments that use a variety of animals to improve psychological well-being in a variety of populations. The interventions include animal-assisted therapy (AAT), a goal-directed intervention in which the animal is a fundamental part of the treatment process designed to improve psychological, physiological, or cognitive functioning; and animal-assisted activities (AAAs), which are less structured interventions that use animals to create a positive environment (Delta Society, 1998). AAAs may be therapeutic but are not required to be (i.e., animals can be used to help ease the anxiety of children learning to read aloud or accompany nervous victims when testifying in court).

Just as animals are being used in a range of interventions with humans, the literature on why animals affect individuals as they do is “spread out over a number of journals and fields, constraining an integrative view” (Beetz, Uvnäs-Moberg, Julius, & Kotrschal, 2012, p. 234). The most current research adopts a biopsychosocial model of health that considers the relationships among biological, psychological, and social aspects of well-being (Friedmann & Son, 2009). The mere presence of animals is able to alter individuals’ perceptions, which in turn affects health; improved health results from experiencing increased psychosocial status and decreased stress response when with an animal (Friedmann & Son, 2009).

Some individuals may dismiss the therapeutic alliance created when a human is partnered with a dog as nonprofessional therapy. However, “personal change that does not rely on experts may create a sense of personal autonomy or personal empowerment that is not obtained in a professional therapy” (Christensen & Jacobson, 1994, p. 12). For Veterans who are trained to be self-reliant and resilient, having a sense of control over their treatment can make the partnership with a dog especially effective. Also, research on psychotherapy has found that “strong therapeutic alliances have proven more effective as variables in client outcomes than treatment techniques” (Yorke, Adams, & Coady, 2008, p. 18).

Trauma negatively impacts an individual’s sense of safety, self-esteem, and self-efficacy, as well as the ability to develop trust; an effective therapeutic relationship must heal these wounds. Because their trauma was caused by another human, individuals with PTSD may experience difficulty forging emotional bonds with others; even interacting with a therapist may trigger PTSD symptoms (Yount, Olmert, & Lee, 2012). AAT protects patients from the risk of “criticism, rejection, evaluation, punishment, inattention, judgment, and unsolicited advice,” which can come from humans (Hamana et al., 2011, p. 1976). Dogs provide an alternative to the pressure to connect to humans as Veterans learn how to manage their symptoms and regain their confidence and sense of safety. The approach promotes Veterans’ resilience against the symptoms of PTSD by developing their coping skills (Taylor, Edwards, & Pooley, 2013). As a result, Veterans gain a sense of empowerment and are less likely to feel controlled by their symptoms.
Much of the research conducted on AAI has been descriptive, using case studies or small samples and lacking control groups (Maujean, Pepping, & Kendall, 2015). As a result, studies are often criticized for their weak designs, and researchers reiterate the call for additional research that uses more rigorous methodologies. Although the number of randomized experimental studies examining AAI is not large, a small collection of high-quality, well-designed research exists and consistently reports positive results regarding treatment effects. Findings indicate evidence of positive impacts on psychosocial and physiological measures.

Rossetti and King (2010) reviewed studies that examined the effect of animal interventions on psychiatric patients with a variety of diagnoses. They found “patients involved in AAT have a notable improvement in their ability to communicate, interact with others, and socialize” (Rossetti & King, 2010, p. 46). Their review of the literature also found benefits to the physical, psychological, and social status of the treatment recipients. Physical effects include lowered blood pressure and heart rate, whereas psychologically, individuals may be able to better express their emotions and build stronger bonds with therapists when an animal is included in treatment. Animals influence social status when they increase individuals’ interactions with others; humans are often more communicative when animals are present. Patients with mood and depressive disorders who received AAT “were better able to control anger, experienced decreased depressive symptoms and feelings of distress, and exhibited reduced anxiety” (Rossetti & King, 2010, p. 47).

Two often-cited meta-analyses reported similar results. Souter and Miller (2007) examined randomized controlled studies of dog interventions that included self-report measures of depressive symptoms and the strength of a treatment effect size. Their analysis of five studies found a statistically significant, medium effect size that indicated the interventions reduced symptoms associated with depression.

Among the studies Nimer and Lundahl (2007) included in their meta-analysis, the most rigorous tests of AAI came from four studies that used an active treatment control group rather than a non-treatment (e.g., a waiting list) control group (because double-blind random assignment is not possible with animal interventions, researchers are increasingly concerned with using an active control group as it can increase the internal validity of the findings). AAI produced better results compared to a photography (Haughie, Milne, & Elliott, 1992) and exercise (Marr et al., 2000) intervention with hospitalized psychiatric populations. AAI’s were as effective as a recreational therapy group in a residential facility with older adults (Bernstein, Friedmann, & Malaspina, 2000) and had higher group attendance compared to other therapy groups in an inpatient psychiatric setting (Holcomb & Meacham, 1989). They concluded that “AAT is a robust intervention worthy of further use and investigation” (Nimer & Lundahl, 2007, p. 234).

The most recent review of randomized controlled studies of AAI on psychosocial outcomes included seven studies (Maujean et al., 2015). All but one study reported beneficial effects of AAI. Two studies found positive effects using farm animals (Berget, Ekeberg, & Braastad, 2008; Pendersen, Martinsen, Berget, & Braastad, 2012), two found positive effects with dogs (Chu, Liu, Sun, & Lin, 2009; Villalta-Gil et al., 2009), and two found positive effects with horses (Bass, Duchowny, & Llabre, 2009; Davis et al., 2009). The only study that did not report positive effects involved dogs interacting with cancer patients (Johnson, Meadows, Haubner, & Sevedge, 2003); one control group interacted with individuals for the same length of time and a second control group read for that time. Neither the canine nor human interaction produced a positive result.

Despite the limited but growing body of rigorously designed studies regarding AAI, research documenting the treatment effects on PTSD is virtually non-existent. A study of equine therapy found civilians reported improvements in their symptoms after learning how to work with horses (Earles, Vernon, & Yetz, 2015). Using a small civilian population with no control group, researchers found interacting with horses reduced PTSD symptoms as well as alcohol use. Participants also reported less severe emotional responses to trauma, less generalized anxiety, and fewer symptoms of depression (Earles et al., 2015).

Another common criticism of AAI research is the lack of theories explaining how or why the interventions work, but biological research seems to provide this explanation. Researchers are increasingly focusing on the oxytocin system of the body. Oxytocin is a hormone secreted by the brain that controls a range of psychological, biological, and behavioral processes, including breastfeeding, giving birth, and empathy and trust (Beetz et al., 2012). Oxytocin modulates “a prosocial, anti-stress brain network” that can influence the anxiety, hyperarousal, isolation, physical pain, and problems with sleep associated with PTSD (Yount, Ritchie, St. Laurent, Chumley, & Olmert, 2013, p. 292). Research indicates positive interactions increase oxytocin levels in humans and dogs when they have physical contact and interact with each other. In studies modeled on strange situation studies with babies and parents, dogs have been shown to have similar behavioral reactions to their owners’ presence and absence as human children (Horn, Huber, & Range, 2013). Dogs bond with humans similarly to babies with their parents. In fact, “the attachment bond that ensues between dog and owner is similar in strength to the psychological bond that forms between human dyads” (Taylor et al., 2013, p. 595). For these reasons, oxytocin is sometimes referred to as the bonding hormone.
Prison-Based Animal Programs

Building on the beneficial nature of human–animal interactions, therapeutic canines are being trained for Veterans by incarcerated individuals. The first formal program to pair animals with a maximum-security population occurred in 1975 at what is today Oakwood Forensic Center in Ohio after inmates found an injured wild bird on the grounds (Graham, 2000). The unit director was impressed by how the usually solitary and unresponsive inmates risked punishment and were able to coordinate their efforts to hide the bird and bring it scraps of food. Although the bird died, the staff noted the camaraderie created by the experience and introduced three parakeets and an aquarium as unit mascots. Soon violent offenders voluntarily participated in a behavior modification program where success was rewarded with the opportunity to eventually care for their own pet. After several years, the program was evaluated by comparing inmates on a unit with animals to those on a unit without animals. The inmates with pets required “half as much medication, had drastically reduced incidents of violence and had no suicide attempts during the year-long comparison. The ward without pets had eight documented suicide attempts during the same year” (Lee, 1987, p. 232).

In the first PAPs in the United States, which date to the early 1980s, incarcerated individuals learned how to groom and train shelter dogs. Today PAPs can be found in countries around the world, including Canada, England, Scotland, Australia, and South Africa (Lai, 1998). Findings from a national survey indicate the programs use a wide variety of animals and encompass a range of designs; in the most common type, incarcerated individuals socialize shelter animals for adoption (Furst, 2006). In other programs, participants may care for injured wildlife, train wild horses, nurse recently born animals, or receive training in animal grooming/handling/care. The programs are administered in most states and most were established after 2000.

PAPs have been shown to have positive effects for incarcerated participants, the environment of the institution, and the outside community (Furst, 2011). Program staff report participants gain a sense of responsibility, learn job skills, and have the opportunity to engage in meaningful work; the programs also have a positive impact on participants’ patience, anger management, and self-esteem (Furst, 2006). In addition, participants report physiological improvements in health, ranging from better sleep to reductions in medication for ailments (including diabetes), as a result of being active with dogs. The dogs serve as social lubricants and become a safe topic of conversation for participants fortunate enough to have family members visit (Furst, 2009). Incarcerated individuals who did not participate in the program and security staff also responded positively to having the dogs (Furst, 2009). The tense and often foreboding prison environment is altered by the presence of the dogs who do not judge those they come into contact with; perhaps ironically, the dogs humanize carceral facilities. Prison administrators, who generally only have the public’s attention on their facility in response to a negative event such as an escape, welcome the positive message the program sends (Harkrader, Burke, & Owen, 2004).

PAPs are not implemented for the primary benefit of incarcerated individuals (Furst, 2006). Usually the programs are created when a nonprofit organization focused on animal rescue, or increasing Veteran welfare, contacts a prison or jail with a superintendent willing to take a chance on the program. The programs are recognized as powerful behavior modification tools. Individuals who want to participate must remain free of infractions and wait lists are usually long; just the possibility of participating and interacting with a dog can alter behavior (Furst, 2006). Unfortunately, little empirical research based on well-designed studies exists regarding the benefits of the programs for participants. Random assignment is virtually impossible in a prison, as not all inmates are eligible for participating in a program; studies use convenience samples as eligible participants volunteer and are therefore self-selected. One of the few pretest–posttest repeated measures design found participants who trained shelter dogs for adoption had significantly improved measures of

KEYPOINTS


1. The number of Veterans with posttraumatic stress disorder (PTSD) is a growing social problem with a variety of significant collateral, including substance use disorders, domestic violence, and contact with the criminal justice system, which can lead to incarceration.

2. Veterans with PTSD can receive therapeutic dogs trained by inmates.

3. A variety of non-profit, non-governmental organizations have been established with the goal of providing Veterans with therapeutic dogs.

4. Organizations training inmates to train dogs use a variety of propriety methods, resulting in dogs with varying levels of training and differing abilities.

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social skill and made progress within the prison’s therapeutic community program (Fournier, Geller, & Fortney, 2007). The passive control group comprised inmates who remained on the wait list for the program.

Veterans and Therapeutic Canines

Civilian groups across the country are building on the therapeutic power of animals and the success of PAPs. Nonprofit organizations are filling the void created by the VA and are providing Veterans with dogs as a form of AAT. Dogs provide a non-stigmatizing, non-pharmaceutical alternative treatment intervention. As with the PAPs that began the trend, the development of the current iteration is organic and with no official endorsement from the government. Citizen-run organizations have recognized the benefits that result from incorporating prison inmates into their program designs. Little empirical research exists about this current trend of Veterans being partnered with dogs but there is ample public and media interest and support (Taylor et al., 2013).

The functions of the dogs trained to assist Veterans with PTSD can be divided into three broad categories: (a) dogs engaging in work that affects the mind/body of Veterans; (b) dogs engaging in physical tasks; and (c) work that uses the dogs’ natural senses (Love & Esnayra, 2009). A common example of mind/body work of dogs is grounding, where dogs recognize and respond to Veterans’ psychiatric episodes (e.g., flashback, dissociative spell). The dogs are trained to respond to Veterans by nudging, barking, or licking (VA, 2013). The dogs serve as an alternative object for focus, tactile stimulation, or therapeutic distraction for individuals needing assistance, regulating their emotions such as when experiencing sensory overload.

Physical work performed by dogs can increase Veterans’ sense of mastery by reducing symptoms and time spent in isolation (Love & Esnayra, 2009). Dogs may wake their partners or turn on lights during nightmares. They may perform a reminder for Veterans with memory disabilities to take their medication. Dogs can provide balance when Veterans walk or assistance in sitting and rising. Dogs can also be trained to circle their partners so others do not come near (Froling, n.d.). By not struggling with seemingly small everyday tasks, Veterans can become more confident that they can participate in civilian life.

The natural senses of dogs enable them to provide support beyond the capabilities of any human. Because, “evolutionarily, humans have learned to judge the safety of an environment by the amount of anxiety exhibited by animals,” calm dogs indicate safe settings (Lefkowitz, Prout, Blelberg, Paharia, & Debiak, 2005, p. 278). Veterans can rely on the dog and have total trust; a dog not displaying fear or aggression indicates through body language that there is no danger. In this way, a dog is like the “battle buddy” a soldier has while in combat (Lutz, 2013).

Dogs also fulfill emotional needs. Pleasurable interaction with a living being can decrease feelings of sadness and isolation, leading to improved self-esteem (Hart, 2000). A relationship with a dog does not pose the same emotional risk as with a human. With dogs, Veterans do not have to be concerned about confidentiality, which can be an issue when the military is the source of treatment. When future employment and eligibility for health and disability benefits are at stake, an authentic alliance can be more difficult to forge. The nonjudgmental nature of human–animal interactions can be especially important for Veterans experiencing feeling stigmatized by mental health care needs.

DISCUSSION

Countless military Veterans need treatment for PTSD but face challenges accessing effective interventions. Research acknowledges that the positive findings associated with AAT have “important implications for use of such therapy with military personnel suffering from combat stress, posttraumatic stress disorder, and other disorders” (Knisely, Barker, & Barker, 2012, p. 30). PAPs stand ready to provide members of the armed forces with the therapeutic tools they need, while saving dogs and creating an opportunity for incarcerated individuals to engage in meaningful work. The approach provides a way to avoid the primary barrier to treatment: the stigma experienced by those seeking mental health services.

Dogs serve as partners as Veterans learn to manage life after military service. The growing need and increasing support for giving prison-trained dogs to Veterans with PTSD indicate the trend may be the start of the next generation of PAPs.

LIMITATIONS

Despite the unique collaboration created when incarcerated individuals train dogs for Veterans with PTSD, there are shortcomings to the approach; these limitations are similar to those that have marked the development of PAPs. No research exists on whether dogs trained in prison are more effective than dogs trained using other methods; organizations claim proprietary methods of training their dogs. The groups are independent and work their own staffs of animal behaviorists and dog trainers. As such, no standardized method of training the dogs exists. Rather than working together in their shared goal of helping Veterans, groups are often competitive; nonprofit organizations are frequently vying for the same limited resources. Without a centralized authority to oversee these grassroots groups, the movement remains piecemeal, impeding its progress and delaying longitudinal research to examine the effectiveness of the dogs. Veterans must locate and contact the groups and be evaluated for eligibility. There is no single agreed upon, scientifically recognized, or standardized way to pair dogs with Veterans.

CONCLUSION AND CLINICAL IMPLICATIONS

The lack of any type of regulation in this field has resulted in a prolifera-
tion of organizations offering dogs that receive various levels of training. Creating a system of oversight to replace the competitive patchwork of nonprofit organizations is the next step—for the sake of the dogs, Veterans, and organizations. Misinformation and the inconsistent nature of training delegitimize the valuable work being done by groups across the country.

REFERENCES

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