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Considerations for Recommending Service Dogs versus Emotional Support Animals for Veterans with Post-Traumatic Stress Disorder

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Keywords: service dog, PTSD, post-traumatic stress disorder, veteran, referral, emotional support animal

Abstract: Background: Health care providers must understand factors that may guide the decision-making process for determining whether a veteran with post-traumatic stress disorder (PTSD) is appropriate for a service dog (SD) versus an emotional support animal (ESA), and assist SD training organizations in determining trained tasks that are suitable for the veteran's needs.

Purpose: This study explored the perspectives of SD training organizations and factors for human health care providers to consider before recommending a veteran with PTSD for a SD versus an ESA. The researchers identified information that providers should give organizations to guide the SD training and placement process.

Methods: A nonexperimental web-based survey research design, including closed- and open-ended questions, was used to collect data. The sample population included SD training organizations in the United States and Canada that train SDs for veterans who have PTSD.

Results: Results suggest that there are skills that can be completed by both SDs and ESAs, and specific tasks that can be only completed by SDs. Health care providers must consider factors related to animal welfare, human cognitive and psychosocial functioning, symptomatology, and expectations when determining if a veteran is a good fit for a SD versus an ESA. For veterans who are appropriate for a SD, information about individual functioning and needs in the above areas can help trainers make the best decisions regarding SD dog matching and training.

Conclusion: Health care providers can play an important role in determining if a veteran with PTSD may benefit from a SD versus an ESA, and help SD training organization make informed decisions regarding SD partnership and training. Health care providers must have a strong understanding of the roles and functions of SDs and ESAs, and how dog partnership may help or hinder a veteran's pursuit of independence in daily activities at home and in the community.

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Introduction

After a traumatic event, some individuals experience persistent symptoms that can have a negative impact on their social and occupational functioning, which may indicate the development of a mental health condition referred to as post-traumatic stress disorder (PTSD). According to the American Psychiatric Association (2013), the symptoms of PTSD are grouped into four clusters: intrusive symptoms (e.g., nightmares, flashbacks, or recurrent memories of the trauma); avoidance of trauma-related stimuli (e.g., avoiding people, places, or situations that cause distressing memories); negative changes in cognitions pertaining to the trauma (e.g., memory impairments, self-blame, or distorted world view); and changes in reactivity and arousal (e.g., anger, exaggerated startle response, or sleep disturbance). It was estimated that 23% of U.S. veterans who served in Operation Iraqi Freedom and/or Operation Enduring Freedom have been diagnosed with PTSD, which is far above the rate of PTSD in the general population (Fulton et al., 2015). The duration of PTSD symptoms in veterans may range from 3 months to 50 years, with symptom recurrence and intensification fluctuating in response to stressors (American Psychiatric Association, 2017).

Current evidence supports treating the symptoms of PTSD by directly addressing thoughts, feelings, and memories of the traumatic event with utilization of interventions such as cognitive behavioral therapy, cognitive processing therapy, and prolonged exposure therapy (American Psychiatric Association, 2017). Despite this, approximately 60% of veterans who receive psychiatric treatment for this condition continue to meet the diagnostic criteria for PTSD (Krause-Parello & Morales, 2018). Due to the persistence of this condition even after participation in treatment, it is essential to identify a means for veterans who have PTSD to maintain optimal quality of life and function. Some veterans are able to accomplish this goal by partnering with a service dog (SD). Others would benefit from a pet that provides emotional support, which is termed an emotional support animal (ESA).

SDs and ESAs are not one and the same in terms of definition and laws. The U.S. Department of Justice (DOJ) defines service animals as "dogs individually trained to do work or perform tasks for people with disabilities" (DOJ, 2015). An ESA is a pet that offers therapeutic benefit by providing companionship and affection to an owner with a verifiable mental health condition (Saunders et al., 2017; Wisch, 2019). The effects of a dog's presence and the provision of emotional support, well-being, comfort, or companionship does not constitute work or trained tasks such as that provided by a SD. Because the emotional support provided by an ESA is not a trained task, individuals who have an ESA do not share all of the public access rights that SD handlers have (DOJ, 2015).

In comparison, SDs for veterans with PTSD perform trained tasks designed to mitigate PTSD symptoms. Some tasks that SDs have been traditionally trained to perform may include checking corners; positioning themselves between a veteran and another community member to increase space (blocking); decreasing hyperarousal as a means to increase community access; waking a veteran up during night terrors by completing a task such as turning the lights on, thereby promoting positive changes in sleeping patterns; and/or alerting the veteran to potential triggers in their physical environment to facilitate improvements in social and work functioning (Crowe et al., 2018; Kloep et al., 2017; Lessard et al., 2018). In addition to benefits derived from trained tasks, veterans have reported a renewed ability to focus on the present, decreased suicidal impulses, improved social functioning, and increased overall quality of life as a result of partnering with a SD (O'Haire & Rodriguez, 2018; Vincent et al., 2017; Yarborough et al., 2018). While veterans with PTSD may consider these trained tasks to be beneficial in helping them to function while living with PTSD symptomatology, there is the concern that some types of trained tasks may reinforce negative thought patterns associated with PTSD symptomology, rather than alleviate those patterns (O'Haire & Rodriguez, 2018). Specifically, some trained tasks (including safety checks, turning on lights in a darkened room, and blocking) may contraindicate evidence-based practice for PTSD

treatment, such as the promotion of habituation and elimination of avoidance behaviors (Kloep et al., 2017). Although previous studies (Crowe et al., 2018) have concluded SDs have a positive impact on many areas of a veteran's functioning, there are significant barriers related to acquiring a SD such as long wait lists, lack of follow-up, and poor pairing and training (Lessard et al., 2018). It is important to consider the potential appropriateness of ESAs for individuals who do not necessarily need a trained SD with public access rights but would benefit from a companion animal. Human health care providers working with veterans who have PTSD can play a valuable role in ensuring the role of the animal will contribute to treatment and progress, rather than hindering it.

Those involved in the care of veterans with PTSD can help them to make educated decisions regarding if and how partnership with an animal may help them. If it is decided that a veteran may benefit from partnering with a SD or ESA, the health care professional may be asked to write a SD referral or ESA qualification letter. Many human health care providers do not have specialized training regarding laws and differentiating roles of SDs and ESAs, although they are commonly requested to write referral letters for veterans applying for SDs and qualification letters for those partnered with ESAs.

SD training organizations may request that human health care providers write referral letters for the veteran applying for a SD because they may not have trained health care professionals on staff. These SD training organizations rely on information from health care providers to better understand a veteran's unique functioning. This information is used to make decisions regarding the veteran's appropriateness and needs for a SD. The human health care provider can offer valuable information to the SD training organization about the veteran's physical, cognitive, and psychiatric functioning and potential recommendations to facilitate a successful partnership.

In contrast, for a pet dog to be considered an ESA, the veteran must have an ESA qualification letter written by a physician or practicing licensed mental health professional (MHP), such as a psychologist or counselor. This letter allows the veteran to bring their animal with them to places in which pets are normally not allowed, including housing where pets are not typically allowed (U.S. HUD, 2016) and airplane cabins (U.S. DOT, 2008). This decision is no small task, as writing a qualification letter without knowing the different roles of SDs and ESAs and potential risks can lead to negative consequences for clients, society, and the animals themselves (Yamamoto & Hart, 2017).

Research Purpose and Question

It is important that human health care providers have an understanding of the client factors that may make a veteran with PTSD appropriate for a SD versus an ESA. With this information, human health care providers can help veterans make the best decision regarding what type of dog is a best fit for them. Additionally, the information that human health care providers supply to SD training organizations helps the dog organizations to make the best decisions about trained tasks that are suitable for the veteran's unique needs. The purpose of this study was to gain insight about the perspectives of SD training organizations regarding client factors for human health care providers to consider before recommending a veteran with PTSD for a SD versus an ESA. The researchers also hoped to identify information that is useful in making appropriate SD matches and guiding the training and placement process. This information was used in conjunction with literature (Esnayra & Love, 2012; Lessard et al., 2018; Yarborough et al., 2018) to develop guidelines to assist providers in determining if a veteran with PTSD is a good match for a SD versus an ESA; trained SD tasks to recommend for a veteran; and information to include in referral letters to SD training organizations.

The following questions guided the research study:

1. What type of PTSD-related desired skills can be completed by a SD versus an ESA?
2. What eligibility factors should a human health care provider consider before recommending a veteran with PTSD for a SD?

3. What considerations should a human health care provider include in a referral letter to SD training organizations?

Methods

Study Design

A nonexperimental survey that included both closed- and open-ended questions was utilized for this study. The study was approved by the University of Tennessee Health Science Center (UTHSC) Institutional Review Board (IRB). After IRB approval was obtained, a solicitation for participation in the survey was emailed to 164 SD training organizations. A member of the research team completed an extensive Internet search of SD training organizations. If an organization's website reported that they train service dogs for people with PTSD, an informational email was sent to the organization's general email address. In order to protect respondent confidentiality, no identifying information of respondents was obtained.

Participants and Sampling

Inclusion criterion for the sample population included SD training organizations in the United States of America and Canada that train SDs for veterans who have PTSD. A nonrandom convenience sample was utilized to recruit respondents for the study. Survey respondents had to be 18 years of age or older and work in some capacity for an agency that trains SDs for people with PTSD. First, potential respondents were identified through an extensive Internet search of SD training organizations for veterans with PTSD. Then, a standardized email was sent to the general SD organization email account to recruit respondents. Those who wished to participate were directed to a secure website to complete an anonymous survey.

Data Collection

Data was collected using a 14-question Web-based survey though UTHSC Qualtrics. Multiple response formats were included in the study, including open-ended questions and closed-ended "check all that apply" questions; optional space was allotted for respondents to provide additional comments on responses to closed-ended questions. Respondents were informed that the survey questions focused on veterans with PTSD and the terms "veteran" and "veteran with PTSD" were used interchangeably throughout the survey questions. Survey questions were developed based on commonly reported variables found in the literature review (Bergen-Cico et al., 2018; Crowe et al., 2018; Esnayra & Love, 2012; Kloep et al., 2017; Lessard et al., 2018; O'Haire & Rodriguez, 2018; Rodriguez et al., 2018; Saunders et al., 2017; Vincent et al., 2017; Yarborough et al., 2017; Yarborough et al., 2018) and addressed questions regarding eligibility criteria, trained SD tasks, roles fulfilled by ESAs, perceived differences between SDs and ESAs, and the role of human health care providers before and after making a recommendation for a SD. The survey had no individual identifiers. The survey was active for 9 weeks.

Data Analysis

Descriptive statistics (including frequency counts and percentages) were utilized to summarize responses from survey questions. The authors reviewed all the responses of open-ended questions and additional comments from closed-ended questions to identify key ideas.

Results

A total of 164 SD training organizations were contacted. Emails containing a link to the survey were delivered to 151 organizations via email without interference and 13 emails were not delivered successfully due to unrecognizable email addresses. A total of 34 respondents completed and returned the survey. Of the respondents, 70.59% ($n = 24$) were from nonprofit organizations and 8.82% ($n = 3$) were from for-profit organizations; 20.59% ($n = 7$) of respondents did not respond to the type of organization they were affiliated with. Out of 24 respondents that were nonprofit,

45.83% (n = 11) were members of Assistance Dogs International (ADI). ADI is an international organization that provides standards and accreditation for organizations that train guide, hearing, and service dogs, including SD for veterans with PTSD.

Trained Tasks Completed by SDs vs. Skills Completed by ESAs

Respondents were provided a list of 17 skills and tasks and asked which would be carried out by a SD. They were then presented with an identical list and asked which would be carried out by an ESA. After this, they were presented with a third identical list and asked to identify tasks that may be incompatible with PTSD symptomology. This data was sorted into the categories of *trained tasks*, *complementary skills*, and *incompatible tasks*. For the purposes of this study, the term *trained task* is used to refer to an individually taught action that is carried out by the dog to address the veteran's needs directly caused by PTSD symptomology. The term *complementary skills* refers to therapeutic benefits naturally derived from canine companionship without training. The term *incompatible tasks* refers to actions performed by a dog that are considered maladaptive coping strategies in the context of traditional PTSD treatment. Refer to Table 1

Table 1 Trained Task vs. Complementary Skills vs. Incompatible Tasks

	Trained tasks	Complementary skills	Incompatible tasks
Wake up veteran during bad dreams/night terrors	24	5	2
Respond to symptoms of high stress (including anxiety, flashbacks, panic attacks, etc.)	23	10	0
Provide extra space in crowded environment	21	1	5
Turn the light on in a dark room before veteran enters	21	1	2
Retrieve another person for help in an emergency	20	4	0
Gain the veteran's attention when people are approaching	19	2	4
Provide deep pressure or tactile input by leaning against the individual	19	5	0
Provide a reassuring presence during sleep	18	20	2
Dog-related responsibilities facilitate a daily routine	17	12	2
Cue veteran to take medication at a designated time	17	2	0
Respond to cue by "bothering" veteran, providing an excuse to leave an overstimulating situation	17	4	2
Orient veteran to time or place upon waking up	15	5	2
Respond to cue by lying on specific pressure points to relieve stress or tension	15	5	0
Check blind corners or entryways	14	0	5
Monitor the environment	13	4	6
Return veteran to a designated location or exit if they become disoriented	13	1	1
Respond to heart rate variability monitor	8	2	2

for a summary of respondents' responses for trained tasks, complementary skills, and incompatible tasks.

A majority of respondents perceived *trained SD tasks* as the following: responding to symptoms of high stress, waking up the handler during bad dreams/night terrors, turning the light on in a dark room before the veteran enters, retrieving another person for help in an emergency, gaining the veteran's attention when people are approaching, providing deep pressure or tactile input by leaning against the individual, and providing a reassuring presence during sleep.

While SDs are specifically task trained to assist with a person's disability, respondents were asked to also identify any other *skills that ESAs may provide veterans*, without individualized training (referred to in Table 1 as *complementary skills*), that may improve their quality of life. Respondents reported skills carried out by ESAs as providing a reassuring presence during sleep, providing dog-related responsibilities to facilitate a daily routine, and responding to symptoms of high stress. Respondents reported that *tasks considered incompatible with PTSD symptomology* included monitoring the environment, providing extra space in a crowded environment, checking blind corners or entryways, and gaining the veteran's attention when people are approaching. Interestingly, there were some tasks, such as responding to symptoms of high stress (including anxiety, flashbacks, panic attacks, etc.) and providing a reassuring presence during sleep, that were considered both a trained task and a complementary skill that could be completed by an ESA. Additionally, providing extra space in a crowded environment and gaining the veteran's attention when people are approaching were considered both SD trained tasks and incompatible tasks.

Factors That May Influence Eligibility for a SD

Respondents were asked to indicate factors that would prevent a veteran from receiving a SD from their organization and should therefore be considered by human health care providers during the recommendation/referral process. The most common factors are directly related to animal welfare, including history of animal abuse or domestic violence, unsafe home environment for a dog, unstable residence, and no long-term plan to financially support the needs of a dog. One respondent stated, "We must advocate for the dog, and therefore most of our exclusions for placement revolve around any indication that we may have regarding the risk that the individual will fail at providing care and maintaining the training of the dog."

A majority of respondents considered unrealistic expectations for the role of the dog a significant factor, although the final decision may depend upon if the veteran is open to modifying their expectations. For example, one respondent stated that "these [unrealistic expectations] are dealt with long before the dog is placed" and another reported that they "may consider [SD placement] if open to realities." Refer to Table 2 for a breakdown of responses related to factors that would prevent a veteran from receiving a SD. For each factor, the frequency with which respondents noted that its presence would prevent a veteran from receiving a SD was recorded.

Contrasting responses regarding disqualifying veteran factors appeared within the additional comments from closed-ended questions. For example, 41% of respondents reported that a disqualifying variable is family members that are not knowledgeable or do not support the veteran partnering with a SD. One respondent reported that the "family must be supportive," while another stated "this would solely depend on the age of the client." A majority of respondents reported that they will not place a dog with a veteran who denies full access to medical records, although this is not a requirement for some organizations. One respondent reported that "since our respondents are referred by their health providers, we do not need to see all the records." Additional disqualifying factors identified from the review of additional comments from closed-ended questions included felony conviction(s), tendencies toward violence, reluctance to follow program guidelines, and lack of veteran's volition to work toward their own progress in recovery.

Table 2 Factors That Would *Prevent* a Veteran from Receiving a SD

	n = 34
Considerations for the welfare of the dog	
History of animal abuse or domestic violence	29
Unsafe home environment for a dog, for example unsafe neighborhood, hoarding, toxic chemicals within a dog's reach	25
Unstable residence	24
No long-term plan to financially support the needs of a dog, including unanticipated veterinary expenses	22
Other dogs living in the home	5
Commitment to mental health treatments	
Not actively participating in mental health treatment	17
Intends to discontinue meeting with mental health practitioner upon receiving a SD	17
Poor medication management, i.e., not taking medication at the right time or in the correct manner	15
Unhealthy/lack of coping skills when faced with anger or stressors	14
Difficulty applying cognitive behavioral strategies, i.e., altering unhealthy thinking patterns	14
Poor insight into mental illness	9
Family and social support	
Family members are not knowledgeable or do not support the veteran partnering with a SD	14
Unable to identify someone available to care for the dog in the case of a long-term hospitalization	12
Another person greatly influenced the veteran's decision to apply for a SD	11
No social support system	10
Medical history	
Denies full access to medical records	19
History of substance abuse	12
High suicide risk	9
Cognition	
Poor problem-solving skills	9
Poor social skills	1
Expectations	
Unrealistic expectations for the role of the dog	23
Does not intend to increase community engagement upon receiving the SD	9

Table 3 presents a summary of responses from respondents regarding dual diagnoses that may prevent a veteran from being eligible to partner with a SD. The most common dual diagnoses present with PTSD that may prevent placement are schizophrenia spectrum, schizoaffective personality disorder, and dissociative identity disorder. However, some respondents noted that veterans are screened for appropriateness by the health care provider, and presence of a dual diagnosis does not exclude veterans. Additionally, specific outcomes of symptomology are considered by some programs; for example, one respondent stated that the veteran would be excluded "only if any of the above were associated with violent tendencies."

Table 4 provides a general timeline that respondents view as appropriate for a veteran to be partnered with a SD. The most frequently selected response was that a minimum of 6–12 months should elapse after the *onset* of PTSD symptoms before a veteran is eligible for a SD. When asked how much time should elapse between PTSD *diagnosis* and SD

placement, the most frequently selected response was that 12–18 months should elapse between formal diagnosis and SD placement.

Respondents who chose to give additional comments to this question provided additional key ideas about the timeline for placement. The first key idea derived from these responses was that determination for appropriate time for placement is not always based on a timeline, but rather the health care provider's clinical reasoning. For example, one respondent stated that "as soon as their psychologist gives them a prescription [referral for a SD], they are eligible"; another respondent noted, "This is where we trust the therapist or doctor to know when the time is to look at a SD for their patient." The second key idea was that the timeline for placement might be fluid, based on the individual's unique experience with the PTSD diagnosis. For example, one respondent reported that "the person needs to have come to terms with their diagnosis and be moving forward" before being considered for a SD; another stated they "want to give veteran time to have some coping skills and adjustment to diagnosis" before SD placement. The third key idea presented by the respondents was that they will begin the placement process immediately upon receiving the referral, with consideration that it is likely to take at least one year to have the dog fully placed with the veteran.

Table 3 Disqualifying Dual Diagnoses

	n = 34
Schizophrenia spectrum	18
Schizoaffective personality disorder	16
Dissociative identity disorder	16
Borderline personality disorder	13
Oppositional defiant and conduct disorders	13
Substance-related disorders	13
Bipolar disorder	9
Antisocial personality	7
Obsessive-compulsive disorder	4
Depression	1
Anxiety	1

SD Referral Guidelines for Human Health Care Providers

At the end of the survey, respondents were provided 3 open-ended questions; responses were categorized based on key ideas. The questions included:

1. What factors make a veteran a solid referral versus an inappropriate referral for a SD?
2. What do you wish health care and human service professionals would consider before making referrals for SDs?
3. With what barriers should health care and human service professionals assist veterans before getting a SD?

Table 4 Timeline for Appropriateness to Procure a SD

	Onset of PTSD symptoms should be present at minimum:	Timeframe after PTSD diagnosis in which it is appropriate to be partnered with a SD:
0–6 months	22.50% (9)	19.51% (8)
6–12 months	**27.50% (11)**	21.95% (9)
12–18 months	22.50% (9)	**24.39% (10)**
18+ months	12.50% (5)	14.63% (6)
Other considerations	15.0% (6)	19.51% (8)

The key ideas identified from respondents' responses to open-ended questions were grouped together to identify factors (in **bold**) to be considered by the health care provider before the application process is initiated. The first factor identified was that **education about SDs and training organizations should be sought out by the veteran and provider,** to ensure realistic expectations of the positive or negative role a SD may play in a veteran's life; understanding of common challenges that may arise during care, training, and community access with a SD; knowledge of SD public access laws; appreciation of appropriate and inappropriate trained tasks; and key differences between a SD and an ESA.

Second, respondents agreed that the veteran and provider should **identify relevant organizations and resources for initial training and ongoing care of a SD, before initiating the application process**. This can be achieved by contacting the SD organization before initiating a referral, identifying how to apply for a Veteran's Administration (VA) dog benefit, and understanding the potential benefit in exploring ADI-accredited programs. Another key factor to be considered by the provider is the veteran's **ability to ensure the dog's health and welfare** by meeting general dog care responsibilities, such as having sufficient financial resources and being able to care for a dog's physical needs. In addition, all parties must ensure that the veteran is educated about and ready for a **long-term commitment to a training program** that includes training/maintaining trained skills, following through with all program requirements, and participating in group training.

Respondents also commented that input from both the veteran and the human health care provider(s) with whom that veteran is actively working should provide relevant information for SD organizations. This information should include release of the veteran's **medical history and progress with the treatment plan** (with their consent), including a detailed history of the veteran's symptoms, timeline of previous inpatient stays, acceptance of their diagnosis, successful intervention strategies, coping strategies that are currently in place, readiness for change, and the level of commitment to their health and wellness. Providers should also ensure there is a **desire by the veteran to increase their engagement in the community and understanding of the barriers that they may encounter when working a SD in public**, such as increased attention due to being in the community with a dog, intrusive questions in public, and ability to work in public places with a trainer. Finally, providers should confirm that there is a **strong social and medical support system** in place.

The results of this survey and findings from the literature review content were organized into a decision-making process that can used by health care providers to determine if a veteran with PTSD would better benefit from a SD or an ESA. This process is outlined in Table 6, which is further described in the discussion.

Discussion

The purpose of this study was to gain insight about the perspectives of SD training organizations regarding client factors for human health care providers to consider before recommending a veteran with PTSD for a SD versus an ESA, and information that human health care providers should supply to SD training organizations to help the organizations make the best decisions about trained tasks that are suitable for the veteran's unique needs. This information was used to develop resources to help providers to determine if a veteran with PTSD is a good match for a SD versus an ESA, and information (e.g., recommended tasks) to include in referral letters to SD training organizations for a veteran with PTSD. Based upon the data gathered from the respondents' responses to closed- and open-ended questions, a set of referral considerations was developed. These guidelines describe factors providers should consider when discussing the potential of SD versus ESA partnership for a veteran with PTSD, recommended/contraindicated tasks for a SD, and relevant information to include in a referral letter to a SD training

organization. Refer to "Summary for Practitioners" and Tables 6–8 for the referral considerations.

When determining if an individual is appropriate to partner with a SD, health care providers should ensure that the tasks that the individual desires the dog to do are directly related to their PTSD symptomology, in order to qualify under the DOJ's definition of a SD (DOJ, 2015). Specific trained tasks and complementary skills can be utilized to address symptoms characteristic of each of the four clusters of symptoms of PTSD (as defined by the American Psychiatric Association, 2013). Respondents identified the tasks and skills most commonly sought out to address PTSD symptomology. Using the framework by Yamamoto and Hart (2017), the researchers sorted these results into categories based on clusters of symptoms. It is important to note that trained tasks are context-specific depending on each veteran's unique experiences, and the following groups are generalized. Trained tasks for mitigating symptomology related to **intrusive symptoms** include retrieving another person for help in an emergency, providing deep pressure or tactile input by leaning against the individual, and waking up the handler during bad dreams/night terrors. Complementary skills in this category (which could be completed by a SD or an ESA) include responding to symptoms of high stress (including anxiety, flashbacks, panic attacks, etc.). Trained tasks that play a role in **avoidance of trauma-related stimuli** include providing extra space in a crowded environment and responding on cue by "bothering" the handler, providing an excuse to leave an overstimulating situation. Trained tasks related to **changes in reactivity and arousal** (potentially viewed as incompatible tasks) may be addressed by gaining the veteran's attention when people are approaching and turning the light on in a dark room before the veteran enters. Complementary skills (which could be completed by a SD or an ESA) in this category include providing a reassuring presence during sleep. **Negative changes in cognitions pertaining to the trauma** may be mitigated by trained tasks such as cuing the handler to take medication at a designated time or a complementary skill such as facilitating a daily routine through dog-related responsibilities. Knowledge of this information can help human health care providers guide veterans in making decisions regarding the type of animal partnership (SD vs. ESA) that would best benefit them and strengthen the collaboration between training organizations and health care providers, thus improving outcomes for veterans. It is critical for health care providers to understand how each skill and trained task will directly impact a veteran's unique symptomology so that the animal (SD or ESA) contributes to treatment and participation in daily activities without adverse effects.

As discussed previously, SDs and ESAs both have the ability to provide complementary skills, which are therapeutic benefits naturally derived from canine companionship without formal training. Interestingly, providing a reassuring presence during sleep was the only complementary skill carried out by an ESA that was identified by the majority (58.8%) of respondents as also being completed by a SD. A majority (65%) of respondents **did not** classify "dog-related responsibilities that facilitate a daily routine" as a complementary skill that could be carried out by an ESA, even though this is a factor that occurs with any type of responsible dog ownership, rather than an active action performed by a trained SD. It is speculated that respondents were reluctant to provide feedback on the role of an ESA due to a potentially negative association with this term. In recent years, there has been an increase in incidents in which individuals bring ESAs or companion animals to a place in which they do not have public access rights, which has resulted in confrontational and dangerous situations for SD handlers, society stepping back in their acceptance of SDs, and an escalation in intrusive questioning for SD handlers with an invisible need (Yamamoto & Hart, 2017). The lack of agreement on the role of an ESA and the common misunderstanding of U.S. laws creates barriers that make it difficult to identify the best option (SD vs. ESA) for veterans with PTSD. Future research should explore the perceptions of SD training organizations regarding the differences in the role of SD versus ESA to help organizations and health care providers make better decisions regarding the most appropriate decisions

regarding the best dog for a veteran. In some situations, a veteran may be appropriate for an ESA but require further progress on goals before having the skills required to be eligible to partner with a SD.

For some veterans, the challenges of partnering with a SD may outweigh the benefits; it is important to identify this prior to initiating the referral process. Responses to the open-ended questions and additional comments for closed-ended questions indicated a need for veterans to be adequately educated about a variety of SD-related topics before initiating the application process, and accepting the likely challenges that will occur during and after the process of partnering with a SD. Approximately 40% of respondents emphasized the importance of knowing about an individual's ability to apply cognitive behavioral and healthy coping strategies to overcome commonly reported obstacles to partnering with a SD. These obstacles include coping with intrusive questions about one's diagnosis and/or unwanted public attention, adjusting to responsibilities associated with maintenance of the SD's training, managing potential health problems of the dog, and addressing unexpected issues throughout the process of acquiring their dog. Based upon this information, it might be beneficial for SD training organizations to provide better educational resources for both veterans and health care providers about the potential obstacles associated with SD partnership, to help them better decide if they can or should pursue SD partnership or may be better suited to an ESA.

Additionally, it is important to consider that some tasks performed by a SD may validate and reinforce an individual's fear that the world is a dangerous place, which is incompatible to promotion of habituation and the elimination of avoidance behaviors (Kloep et al., 2017). Our results indicated tasks that may be perceived as contraindicated with PTSD symptomology include monitoring the environment, checking blind corners or entryways, providing extra space in a crowded environment, and gaining the veteran's attention when people are approaching. However, it should be noted that only 6 respondents out of 34 (18% of total respondents) identified incompatible tasks, which could indicate that this is an element that is being overlooked across other training organizations. For this reason, it is important that referrals include detailed information such as history of symptoms, trained tasks to best benefit a veteran's needs, specific tasks that could potentially be contraindicated based upon the veteran's current treatment plan, and successful interventions that are being utilized. It is essential that the veteran, health care professional(s), and training organization collaborate to identify trained tasks to best facilitate the veteran's independence and avoid potentially halting progress within PTSD treatment. Some veterans may be seeking out a SD to complete incompatible or unrealistic tasks, which may be indicative that they are not appropriate for a SD at this time. Each SD training organization has their own protocols and standards utilized to determine if a veteran is eligible to partner with a SD. The results of our study indicated inconsistent perspectives in relation to the general timeline (Table 4) for when SD training organizations perceive it is appropriate for a veteran to be partnered with a SD. Before referring an individual, health care providers should consider whether the veteran is at a place in their PTSD treatment to take this step, or whether it would be more appropriate for them to wait until further skill development has been achieved in treatment. Half of the respondents perceive a veteran's commitment to mental health treatment as a prominent factor when determining a veteran's eligibility. Before making a referral, providers should consider client-centered factors in relation to the treatment plan, such as how a SD could contribute to ongoing treatment, the veteran's previous and current commitment to treatment, and the long-term plan of care, including termination of services. While a SD's role may address an individual's symptoms to improve their ability to participate in activities of daily living and performance patterns that are meaningful to them, it should be made abundantly clear to the individual that this partnership will not completely resolve their symptoms of PTSD and should not be considered a substitution for ongoing mental health services.

The results of the study demonstrated that each SD training organization has varying perspectives and procedures for addressing variables that may

Table 5 Allocated Responsibilities Before Referring or Applying for a SD

	Health Care Provider	Training Organization	SD Veteran
Education to ensure realistic expectations	X	X	X
Identify appropriate organizations and resources before initiating application process	X		X
Ability to ensure the dog's health and welfare	X	X	X
Long-term commitment to the training program	X	X	X
Provide medical history and information regarding progress with the treatment plan	X		X
Desire to increase engagement in the community and understating the barriers that will likely coincide	X	X	X
Strong social and medical support system	X	X	X

disqualify a veteran from SD partnership. Health care providers are not expected to be experts in the field of SDs and ESAs, but they are able to play an important role by providing enough information to allow SD training organizations to develop a clear picture of how the symptoms of PTSD impact a person. Many SD training organizations that work with veterans who have PTSD require referral letters from human health care providers to help them "filter out" individuals who may not be appropriate for a SD and facilitate informed decisions about the veterans who could be best helped through SD partnership. Given the depth and breadth of information that organizations said it would be beneficial to have, it may be useful for training organizations to collaborate with health care providers to develop a more comprehensive referral process. Table 5 outlines the responsibilities of each party involved in the process of determining a veteran's eligibility to partner with a service dog. These responsibilities are based on survey responses and literature review.

Limitations

The generalizability of the findings of this study may be limited by the small sample size. Factors were not considered regarding each SD training organization's training protocol, such as whether the veterans were placed with an already trained SD or if the veterans self-train a dog. Therefore, the results of this study may not be reflective of all SD training organizations or may reflect differences between organizations that provide trained dogs versus self-training services. Additionally, it is possible that there was confusion among respondents regarding what constitutes a trained SD versus an ESA. Future surveys should include definitions of terms and descriptions of trained SD tasks versus ESA skills.

Future research should focus on all individuals (not just veterans) who have PTSD who may be considering animal companionship in the form of a SD or ESA, to study the benefits and challenges of SD partnership or ESA ownership. Finally, additional studies should be completed regarding the impact that some trained SD tasks may have on progress with PTSD treatment to determine if they are truly incompatible tasks.

Summary for Practitioners

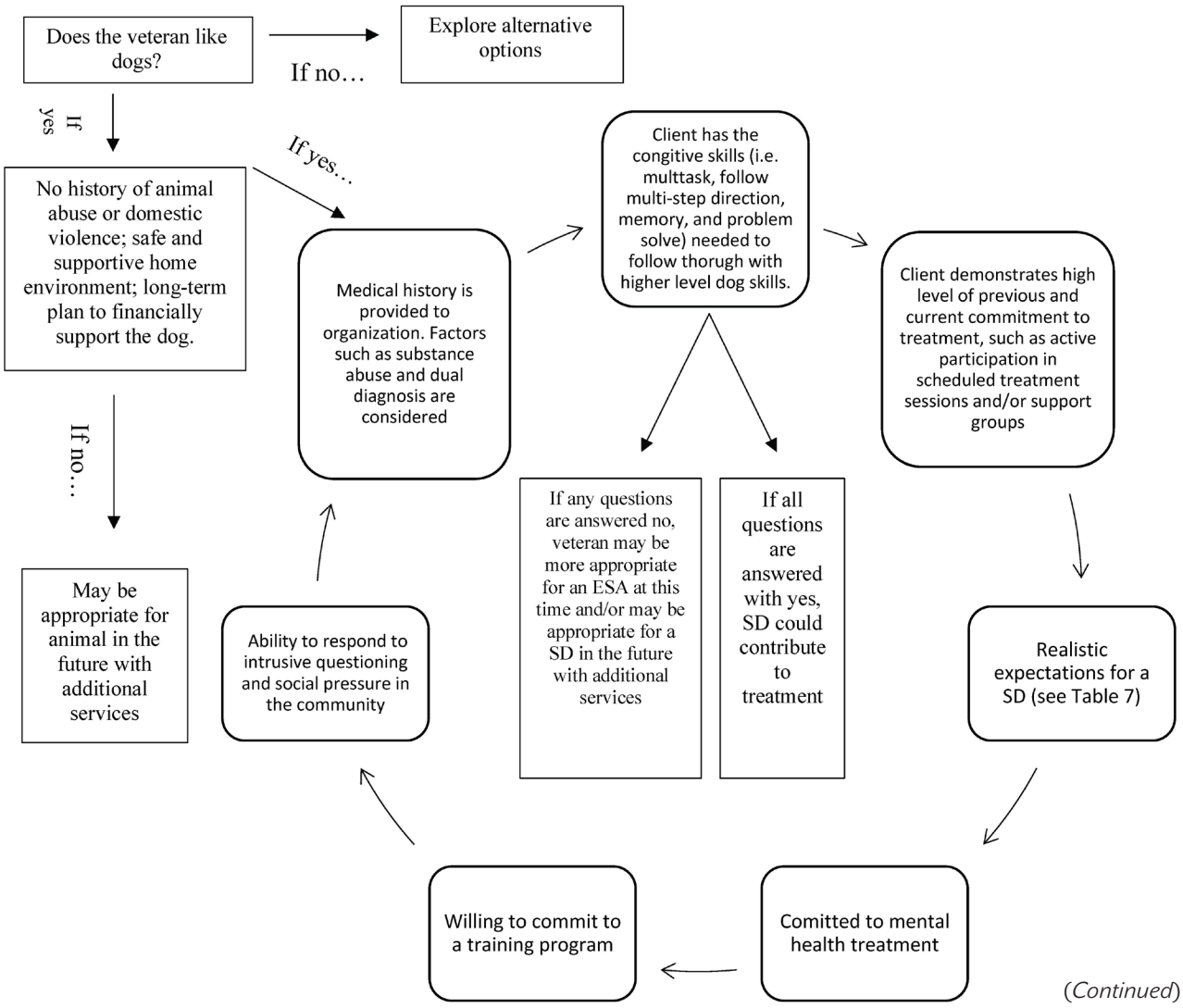
Health care providers can play an important role in determining if a veteran with PTSD may benefit from a SD versus an ESA, suggesting the types of

trained SD tasks that may be indicated and contraindicated for a veteran, and providing a referral letter that helps the SD training organization to make an informed decision regarding SD partnership and training. Prior to discussing the potential appropriateness of SD versus ESA partnership with a veteran, health care providers must have a strong understanding of the roles and functions of SDs and ESAs, and how a trained SD may help or hinder a veteran's pursuit of independence in daily activities at home and in the community. The provider should also be alert for the presence of factors (outlined in Table 6) that may warrant a client is inappropriate for SD partnership.

Once a health care provider and veteran make the decision to pursue SD partnership, the provider must consider the client's symptoms, treatment goals, and coping strategies that could impact which trained tasks would be appropriate for the client (see Table 7). This information can ultimately be used by the SD training organization to help them make appropriate training decisions.

Finally, when writing the referral letter to the SD training organization, the provider should include

Table 6 Factors to Consider Before Referring a Veteran with PTSD for a SD



(*Continued*)

Table 6 (*Continued*)

Welfare of the dog. Red flags and disqualifying factors include: • A history of animal abuse or domestic violence • Unsafe home environment or unstable residence • No long-term plan to financially support the dog
Are their family members supportive?
Does this person have the cognitive skills needed to train? (multitask, follow multistep direction, memory, and problem solve)
Commitment to mental health treatment: • Veteran's previous and current commitment to treatment • How could a service dog contribute to treatment? • The long-term plan of care, including termination of services
Medical history: • History of substance abuse • Denies training organizations full access to medical records • Dual diagnosis (i.e., schizophrenia spectrum, schizoaffective personality disorder, and dissociative identity disorder)
Are their expectations for trained SD tasks realistic? (See Table 7)
Are their expectations for the role of the dog more suited for an ESA? This might include providing a reassuring presence during sleep, providing dog-related responsibilities to facilitate a daily routine, responding to symptoms of high stress, and other skills that do not require public access.
Are they committed to mental health treatment? Can they commit to a training program?
How do they respond to intrusive questioning and social pressure?

Table 7 Trained SD Tasks That May Benefit a Veteran with PTSD

Questions to consider:
- Do the tasks address symptoms or outcomes of PTSD as defined by the DSM-V?
- Will these tasks improve community exploration?
- Are any desirable tasks contraindicated to the treatment plan?

Potential barriers/symptomology:	**Potential trained SD tasks:**
Commonly experiences night terrors	Wake up veteran during bad dreams/night terrors
Difficulty in crowded environments	Provide extra space through "blocking"
Becomes disoriented in public spaces	Retrieve another person for help in an emergency
Hyperarousal, startle response	Gain veteran's attention when people are approaching
Self-regulation is improved by sensory input	Provide deep pressure or tactile input by leaning against the veteran or respond to cue by lying on specific pressure points to relieve stress or tension
Difficulty with medicine management	Cue veteran to take medication at a designated time
Difficulty staying in community environments	Respond to cue by "bothering" veteran, providing an excuse to leave an overstimulating situation
Experiences anxiety, flashbacks, panic attacks, etc.	Respond to symptoms of high stress with a designated skill (placing head on lap, bringing a toy, directing them to a designated location, etc.)

Table 8 Information to Include When Writing a Referral Letter for a Veteran for a SD

What trained tasks might contraindicate the treatment plan? (i.e., monitoring the environment, checking blind corners or entryways, providing extra space in a crowded environment, and gaining the veteran's attention when people are approaching)
Can the dog be incorporated in treatment to facilitate graded exposure? If so, what would this look like? Who would facilitate this?
Input from the mental health provider(s) with whom the veteran is actively working, including a detailed history of symptoms, successful intervention strategies, and a list of tasks that would benefit the veteran
Have they owned a dog before?
What is the veteran's learning needs? What type of accommodations will best benefit them during the training program?
What are their known triggers? How are those currently being addressed?

detailed information regarding factors that could ultimately impact if and how a dog is placed with the veteran (refer to Table 8). In particular, it is helpful to provide details regarding the veteran's history of symptoms and treatment; how a SD will be integrated into the veteran's plan of care; tasks that are recommended and contraindicated (based upon the veteran's symptoms and treatment plan); and recommendations for accommodations to help facilitate veteran success during training (i.e., learning styles, triggers, etc.).

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