More Than Just a Break from Treatment: How Substance Use Disorder Patients Experience the Stable Environment in Horse-Assisted Therapy

Ann Kern-Godal[1,2,*], Ida Halvorsen Brenna[1,*], Espen Ajo Arnevik[1,3] and Edle Ravndal[2]

[1]Department of Addiction Treatment, Oslo University Hospital, Oslo, Norway. [2]Norwegian Centre for Addiction Research (SERAF), University of Oslo, Oslo, Norway. [3]Department of Psychology, University of Oslo, Oslo, Norway. *These authors contributed equally to this study.

ABSTRACT: Inclusion of horse-assisted therapy (HAT) in substance use disorder (SUD) treatment is rarely reported. Our previous studies show improved treatment retention and the importance of the patient–horse relationship. This qualitative study used thematic analysis, within a social constructionist framework, to explore how eight patients experienced contextual aspects of HAT's contribution to their SUD treatment. Participants described HAT as a "break from usual treatment". However, four interrelated aspects of this experience, namely "change of focus", "activity", "identity", and "motivation," suggest HAT is more than just a break from usual SUD treatment. The stable environment is portrayed as a context where participants could construct a positive self: one which is useful, responsible, and accepted; more fundamentally, a different self from the "patient/self" receiving treatment for a problem. The implications extend well beyond animal-assisted or other adjunct therapies. Their relevance to broader SUD policy and treatment practices warrants further study.

KEYWORDS: substance use disorder, equine-assisted psychotherapy, patient perspective, self-concept, social construction, treatment context

CITATION: Kern-Godal et al. More Than Just a Break from Treatment: How Substance Use Disorder Patients Experience the Stable Environment in Horse-Assisted Therapy. *Substance Abuse: Research and Treatment* 2016:10 99–108 doi: 10.4137/SART.S40475.

TYPE: Original Research

RECEIVED: July 01, 2016. **RESUBMITTED:** August 29, 2016. **ACCEPTED FOR PUBLICATION:** September 04, 2016.

ACADEMIC EDITOR: Gregory Stuart, Editor in Chief

PEER REVIEW: Three peer reviewers contributed to the peer review report. Reviewers' reports totaled 625 words, excluding any confidential comments to the academic editor.

FUNDING: AKG was funded by the Norwegian Research Council and the Swedish–Norwegian Foundation for Equine Research. The authors confirm that the funder had no influence over the study design, content of the article, or selection of this journal.

COMPETING INTERESTS: Authors disclose no potential conflicts of interest.

CORRESPONDENCE: ann@godal.com

Background

Remaining in and completing substance use disorder (SUD) treatment is associated with improved prognosis.[1–3] Preventing treatment dropout, which often exceeds 50%, is a constant challenge to those engaged in SUD clinical, policy, and research work. Treatment retention and effectiveness have been linked to interrelated patient, therapeutic, and environmental factors, and to elements of engagement[3] and identification[4] with the treatment program. The broad social-environmental context in SUD treatment motivation is said to be underestimated and in need of investigation,[5] as are the treatment processes or "mechanisms of action."[6] In addition, there is increasing recognition that patients themselves can add valuable information about treatment processes, as Neale[7] demonstrated with her study of drug service provision and its implication for service use and nonuse. More recent studies of patients' perspectives have illustrated the importance of ordinary, everyday, and commonplace communication between staff and those in psychiatric or SUD treatment.[8,9]

There is increasing popularity for alternative or complementary health treatment methods, such as yoga, art, music, gardening, or animal-assisted therapy, for SUDs.[10] A well-documented example is Decker et al's "Natural Recovery Program," which found that SUD patients who participated in an adjunct "hobbies" intervention involving art, music, or gardening had better satisfaction and were more likely to remain in and complete their treatment.[11]

Horse-assisted therapy (HAT), an innovative psychotherapy that actively involves horses in the therapeutic process, is one such complementary (free-standing) or adjunct health-related activity. An increasing volume of HAT literature claims benefits to health based on explanations more or less founded in psychological theories[12] such as attachment[13] and psychoanalysis.[14,15] Other explanations focus on the characteristics of the horse.[16,17] The outdoor, active, and less verbal therapeutic environment of the stable (as compared to the verbal and enclosed atmosphere of the therapy room) is also regarded as more beneficial for some clients.[18,19] Reviews of HAT literature indicate a growing and diverse field but draw attention to the need for improved methodology and theoretical analysis.[20–23] Few HAT studies focus on either SUD or on participants' own experiences of HAT.

In 2011, the Department of Addiction Treatment (Youth), Oslo University Hospital, embarked upon a multifaceted, mixed methods study of HAT as an integral part of its SUD treatment program.[24] As previously reported, those who participated in the HAT program remained in treatment for a significantly longer period and were more likely to complete their agreed program of treatment.[25] A subsequent qualitative study,[26] which focused specifically on the patient–horse

relationship in HAT, found that participants perceived the horse to be an important facilitator of a positive self-construct and an emotional support during treatment. These findings were found to relate to SUD[27] and HAT[13] attachment theories. In another study of the reasons for dropping out of treatment from the same institution, participants spontaneously cited HAT as a rare, positive aspect of their SUD treatment. While not mentioning horses specifically, they emphasized the activity and exercise aspects of time spent in the stable.[28]

The horse obviously has a pivotal role in HAT.[26] However, there appear to be important physical, social, and emotional contextual aspects of the HAT stable environment that deserve further study.[16,29] In this study, we use the terms "stable environment/context" to refer to non-horse-specific aspects of HAT, and "huset/house" to refer to the SUD treatment as usual program/residential quarters.

Objective

The study aims to obtain a better understanding of how patients experience the stable environment and other contextual aspects of HAT as part of their SUD treatment process, and the meanings they attribute to that experience.

Material and Method

Context. The Department of Addiction Treatment (Youth)'s treatment is a person-centerd program comprising individual and group therapy based on a biopsychosocial model with emphasis on mentalization-based theory and practice.[30] Patients enter the program after detoxification. Psychological treatment is provided according to the individual's specific problems and treatment goals. Medical treatment is offered, plus assistance/counseling on accommodation, education, employment, as well as post-treatment living, adjustment, and support. Patients in residence spend their time, according to their treatment plan, in individual or group therapy. They can participate in structured or unstructured recreational activities, but HAT is the only adjunct therapy component of the Department's SUD treatment program.

At the time when the study was undertaken (autumn/winter 2012–2013), the Department was undergoing major organizational and staff changes. Different levels of treatment (assessment/intermediate, day, and inpatient) were targeted at young adults aged between 16 and 26 years (exceptionally to 35 years of age), with problems related to substance misuse. All treatment units were located in an area adjacent to the stables, where the horses were visible.

The stable housed five horses, of different breed, appearance, and temperament. Each horse was carefully selected, trained, and exclusively used in therapeutic work with SUD patients. They were safe but displayed the typical horse herd social and reactive behavior to humans.

Experienced therapists, who were also qualified riding instructors, were responsible for HAT. They provided a structured 12-session therapy program. During the first four sessions, patients became familiar with horses, learned about equine behavior and safety, and were introduced to the basic skills of horse care, handling, and equipment. All participants, including those with previous experience with horses, participated in these introduction sessions. In the subsequent eight sessions, the patient and therapist worked through activities and exercises with the horse, which were directed at agreed goals. The time in the stable was a carefully planned part of patients' overall treatment plan. The HAT therapeutic team emphasized that the activities with the horses were intended as therapy and not as recreation or riding instruction.

Recruitment. Purposeful sampling (to maximize variations in gender, treatment unit, and number of HAT sessions) was used[31] with the primary criterion of at least 1 hour of HAT experience. Snowball sampling was used insofar as some participants talked with others, helping to recruit them into the study. No patient refused the invitation, but some HAT participants were not invited because their therapists advised that the interview may have been detrimental at that point in their recovery process. After eight interviews, it appeared that little additional information or new perspectives were forthcoming, so no further participants were sought.

Participants. The study sample consisted of eight participants, aged 20–30 years. Their average age at the time of interview was 24.8 years. Four of the participants were women, and four were men. They were recruited from among patients undergoing treatment at the institution, who had agreed to participate in research, were registered in the Department's Youth Addiction Treatment Evaluation Project (YATEP) database before end 2012, and were participating in the HAT program between November 2012 and end-January 2013. At the time of the interview, the participants were at different stages of their treatment program. Five were residents at the inpatient unit, two were residents at the assessment/intermediate unit, and one attended the day-treatment unit. None was under mandatory court or legislative sanction. Three were experienced riders. The others had no experience with horses prior to HAT.

The researchers. Researchers' own background, situation, and interests influence study choices and the research methods used.[32] The authors of this paper include a mix of relevant academic (sociology and psychology) and practice (addiction treatment and health management) backgrounds. The two first authors have owned and worked with horses in various capacities over many years. Their coauthors are constantly in search of innovative means to improve SUD treatment and retention.

Development of the study. The first author was familiar with the Department, having worked for some years in the HAT program, and was familiar with international HAT literature and developments. In early 2012, she pilot tested a semistructured questionnaire in English with four long-standing patients (three men and one woman) with

whom she had good rapport. The aim was to obtain a better understanding of the patients' perspective. Although each of the participants responded openly, the results were judged to be rather static, predictable, and possibly too enthusiastic. Their responses could have been influenced by the use of English and an interviewer whom they knew well. The pilot indicated the need for a Norwegian interviewer, closer in age and background and less well known to the participants.

A 2-month planning phase enabled the second author (a Norwegian) to gain a sense of the overall therapeutic context, and to become familiar with the stable environment and the HAT program. During this time, the interview guide was constructed (by the first and second authors) using a framework within which respondents could express their own understandings in their own terms.[31] The underlying principles for the analysis were the recognition of participants' experience as constructed through the words they used, rather than a static and objective source of information, and the recognition of participants' use of language as a social action – how they used words to construct certain realities.

The scope of the interview was HAT in the context of SUD treatment. It was sufficiently broad and open to enable participants to elaborate on their experiences in the stable, including their experiences with therapists, horses, other patients, and the nature and the meanings of the activities involved.

The theoretical framework. Lancaster and Rytter[33] draw attention to the largely overlooked importance of social construction in drug "evidence-based policy." Different voices and knowledge can contribute to and influence the contested drug policy field, but the SUD patients' views are rarely heard.[34]

Social constructionism, grounded in a postmodern, relativist understanding of data, implies an acknowledgment of the constructed nature of knowledge, as opposed to knowledge being discovered. It also implies that people's understanding of the world is historically and culturally dependent: we live in a certain context that creates certain understandings.[35]

The objective of the current study, namely how patients constructed and interpreted their experiences of HAT within a SUD treatment context,[36,37] indicated the need for a phenomenological study within a social constructionist framework.[31,35,38] We worked from a realist ontological and relativist epistemological position, namely that knowledge is contextual and is constructed from social, historical, cultural, and political influence and interpretation: that is, a position of empirical critical realism "to find the best explanation of reality through engagement with existing fallible theories about that reality".[39(p. 6)] Our subsequent interpretations are guided by contextual sensitivity.[31] In this we raise possible influences on the social-environmental context of both recognition (the significance of how one recognizes and is recognized by others)[40,41] and social/emotional geography (the relationship of space and environments to social and emotional relations and well-being).[42–44]

Data collection and analysis. Data on the eight patients' perceptions of both the horse-specific and other aspects of HAT were collected over a 10-week period from late November 2012 to late January 2013 using semistructured interviews, which were conducted by the second author in Norwegian within the stable/department environment and recorded on a digital audio recorder. She then transcribed, coded using HyperRESEARCH (Researchware, Inc.), and analyzed the data in Norwegian using thematic analysis based on Braun and Clarke's[45] suggested six steps: (1) getting familiar with the data; (2) generating initial codes; (3) searching for themes; (4) reviewing themes; (5) defining and naming themes; and (6) producing the report. The outcome from this analysis was presented to three of the participants who were still in treatment, and to the HAT staff. This resulted in some factual elaboration but no change to the themes identified.[46]

For the current study, the full transcripts for each participant were reviewed by the first two authors. All transcripts were reread, reflected upon, and debated in order to identify aspects of HAT and the meanings attributed to those aspects. Thematic analysis, as understood within a social constructionist framework, was used to "identify patterns across the dataset in relation to the research question".[47(p. 2)] Conscious of contextual influence, we also used Patton's contextual sensitivity and assessment guide[31(p. 71)] in reaching conclusions.

Language translation. Cross-language studies are increasing with globalization. They present methodological issues, including possible barriers between researchers and participants, co-researchers' misunderstanding or misinterpretation of meaning, and translation challenges, including when to translate data.[48,49] All of these issues can affect the study results. In order to maximize representation of the patients' perspectives and meanings, our interviews were conducted, transcribed, and analyzed in Norwegian.[48] The quotations were translated for inclusion in the manuscript (by IHB who is Norwegian and fluent in English, in consultation with AKG, English mother tongue with rudimentary Norwegian). Finally, accuracy was checked by retranslation back into Norwegian[49] by an independent person (fluent in both languages, experienced in HAT and familiar with the language of young substance users). No major differences in meaning were identified in the retranslation.

Ethics. All necessary patient consent and data inspection authority's approvals were obtained as part of the YATEP. The study was reviewed and approved by the Norwegian Regional Committee for Medical Research Ethics and performed according to their guidelines and the Declaration of Helsinki. Patient participation in research was voluntary, and all participants signed the required informed consent.

Patient details such as gender, age, and name are not used for reasons of anonymity and confidentiality. Instead, when quoting, we simply refer to patients numbered (P.1) to (P.8). Similarly, the names of the horses, which in some cases could identify the patient, have been omitted.

Results

Apart from the previously reported relationship with the horses,[26] *a break from usual treatment* best describes and is most connected (directly or indirectly) with key aspects of the participants' therapeutic experiences of HAT. We identified four interrelated aspects (or categories) of "break from usual treatment," namely "change of focus", "activity", "identity" and "motivation."

Change of focus: "forget everything". All participants highlighted HAT as a pleasant variation from their usual treatment and as something to look forward. Interestingly, none of our participants mentioned the very obvious environmental and physical differences of being in the stable, such as being out in the open air, the cold (the interviews took place over winter months when temperatures are well below freezing point), or the smell and dirt that are an inevitable part of stable work. Rather, for some it was "a nice break from the day" (P.7) or having an enjoyable thing to do "…it's fun to ride, it is" (P. 6) or less boring than just "sitting in a room" (P.6). For others, being in the stable was associated with specific and positive affect: "I'm always really happy when I'm going down to the stable (….) I can feel it, that it is very positive for me" (P.2).

For most, however, relationship issues, with self and/or others, were alluded to as the most important part of the changed focus associated with HAT. For some, being in the stable provided an opportunity to focus on "the here and now" (P.2), to turn their attention away from their own, often troublesome, issues and "forget everything" (P.2) until "I'm done down here, and on my way back (to "huset"/the house, when), everything comes back …" (P.2). For others, as Burgon[14] found in her study of young at-risk people, the break was about the relationships that developed, not just with the horses and staff, but also with other participants: "I learn to be more caring about other people and learn to be responsible, both for myself and others" (P.4).

Activity: "doing something useful". Activity, as well as the opportunity to do something productive, was highlighted by most participants as an important part of the HAT "break", best illustrated in the words of one participant who said "first and foremost I like to work" (P.2). Participants also readily communicated through these expressions of "doing something useful" (P.3) their recognition of the sense of purpose and well-being associated with meaningful engagement in productive activity: "I feel that I do something. Something that's important – to others, and of course, that's a good feeling" (P.4). Simple, pragmatic aspects of HAT work, like feeding the horses or helping to stack the hay, were seen as both different and important because they were seen as necessary:

> It's animals that need food and care, and they need…. they need humans to survive, at least the horses here do. So it feels good in a way…that I can make a difference and contribute with something, something positive (P.4).

Furthermore, the positive affect evoked by HAT staff's appreciation of participants' work in the stable did not go unnoticed: "I like to do stuff, and especially because the others appreciate it. That gives me a lot" (P.2). The more constructive mind frame, associated with productivity and appreciation, was also noted: "Instead of getting mad and sitting on your hind legs so to speak, you find the solutions" (P.2).

Participants, in response to a question about the therapeutic nature of HAT activities, were generally not very specific "… it's therapy, at the same time as it's a kind of pastime. And it is something I think is fun. So, it's both (therapy and activity)" (P.4). This was in contrast to some who explicitly linked activity to a perceived therapeutic value by expressing a feeling of commitment and responsibility, and of feeling useful and appreciated:

> Mostly, it has to do with the responsibility. To have someone that is dependent on you, because it becomes a commitment. That's not something I've been that good at earlier. So I have absolutely found something in the horse therapy (P.4).

Other studies of clients' experiences of addiction treatment have identified participation in meaningful activities as important to patients.[11,28] Dahle and Iversen found "meaningful activity" to be one of four important treatment aspects identified by Norwegian SUD patients.[50] It continues to be a treatment concern in Norway.[51]

Identity: "who I really am". During the interviews, participants seemed to share an idea about the "real me", which was sometimes present and sometimes not, and which some people (or animals) would acknowledge and some not. Participants said they felt that both the horses and the HAT team appeared to recognize them as persons and implied a contrast with their experience of "usual" treatment at "huset/the house".

Most participants highlighted their relationship with the HAT team as different from their relationship with other therapists and staff. The HAT team was generally described as more friendly than traditional therapists. Several participants implied that they did not see the HAT team as therapists but as friends. Others were clear about their view of the HAT team as therapists, but emphasized the HAT team's different approach: "They don't talk about drugs" (P.2) and other problems; they don't ask "difficult questions" (P.4); and "they treat me as who I really am" rather than as "a patient" (P.5).

Participants also described the atmosphere in the stable environment as being different and more relaxed than at "huset/the house". The focus in the stable was on interaction with the horses and the associated necessary and routine stable work where the HAT staff generally worked alongside patients doing stable duties. Participants implied that the HAT team acted toward them in a way that gave them a sense of being

normal people. It was implied that the experience of being included in the stable working environment also gave participants a sense of belonging, and direction:

> When I come down to the stable, there's no talk of drugs, or thoughts about drugs at all, it's just to focus on the horses and how the day in there will be, in the stable. (….) So I feel I can learn a lot from the girls in the stable, because they are so sure when they are in the stable. And that makes me calm down, feel secure with them and with the horses, (and) I want to be there even more (P.3).

To explain the sense of difference that the participants describe experiencing in the stable, it is necessary to say something about how they talked about being a patient. Participants had explicit thoughts about their expectations of treatment and about what outcomes they should expect from therapy. Most participants had thoughts about what kind of treatment was right for them and what treatment did not work: for example, as we found in a previous study of the reasons for dropping out of SUD treatment,[28] whether direct confrontation about SUD and their use of drugs and related problems worked for them, or whether a less direct approach that focused on accessing their positive personal resources to overcome addiction was more beneficial. All the same, participants expressed different levels of involvement in their own treatment. Some described being in treatment as "being kidnapped" (P.1), "being driven around" (P.1 and P.5) or "having medication increased" (P.1), while others had a different sense of responsibility concerning the outcome of their treatment:

> It is an individual treatment and it depends on what you make of it yourself. And that's really good for me because then things can go the way I want them to. And what's supposed to happen, I make happen (P.2).

The participants with previous experience with horses were able to describe an even more active participation in HAT when they talked about the horses and their relationship and activity with the stable staff. They implied that they found added meaning in the stable and working with the horses because they could use their knowledge and skills. "The thing is that I know how to take care of horses and so on…… So I feel that's something I can do." (P.1). In so doing, they could experience a sense of self-worth and well-being; they could recall and reflect upon positive aspects of their previous life:

> Everybody has one thing in their life they can go to. Or probably there are some people who don't and that must be really bad. But that's (working with the horses) kind of the one thing in my life that I can do, to get a break, and to get away from the bad feelings, and to flee from that kind of stuff. In a good way (P.5).

The underlying identity issue is well illustrated in P.5's description of how she experienced the HAT therapeutic team's approach in comparison with that of other therapists:

> They probably keep in mind that we are patients, and that we are emotionally fragile and so on. At the same time as they work in a way where they don't ask and nag and treat us like we were inferior or like we were. Yes, it's just like we… like I used to feel when I was in the stable before (outside the hospital), that I am a rider, I'm not a patient (P.5).

Motivation: "why I'm still here". Many studies of therapeutic work involving horses refer to the motivational benefits.[12,17,52–56] Any factor that makes treatment more enjoyable or endurable may also contribute to the participants' sense of being able to finish treatment.

HAT was an obvious inducement for some (young women in particular) to come to the treatment unit in the first place and then to remain there:

> I was really happy about it. (….) I remember I ran down but I had to wait, to talk to the people in the stable first. But I started pretty early. It was like, in fact I think it has been, much of the reason why I'm still here (P.1).

Others described HAT's beneficial "non-drug" focus as enabling positive forward thinking:

> There's no talk of drugs, or thoughts about drugs at all, it's just to focus on the horses and how the day in there will be, in the stable. It's very good motivation to think ahead in my life (without drugs)" (P.3).

While most participants described having an interested or positive reaction when they first heard about the horses, two participants (P.4 and P.7) came to the unit with a very indifferent or downright negative attitude to horses: (P.7) described thinking of horses as "big, and ugly and spooky" before experiencing HAT. Both described how they gradually had become more open to the possibility of participating in HAT, and how their attitude to the horses had changed when they had spent some time in the stable. Both participants expressed a similar change in their attitude to HAT as part of the treatment, and identified aspects of HAT they considered to be of therapeutic value.

Conversations with staff suggested that patients who were not interested in undergoing HAT also displayed least motivation for treatment in general. This was particularly relevant to one of the participants in the present study, who said that he initially was negative to the horses and HAT. However, as he became more motivated to succeed in treatment, he also became more open and curious about the therapeutic effect of the horses.

Another participant said that the horses had little to do with motivation for succeeding in treatment, or for seeking treatment in that Department in the first place. "I would still be here even if there was no horse therapy. So it wasn't like it was what made me choose. (….) I'm not going to be with the horses anymore. But I'm still going to be at "huset/the house" (P.2).

However, the majority described HAT as motivational. The overall motivational effect of HAT was perhaps best demonstrated in the words of P.1 who said:

> Overall, the horses and the riding have been much of the reason why I'm still able to be here. I have struggled a lot now the last month. Every day has been a huge fight, and I just sit and clutch the table. It's obvious that those days, when I ride, then the day passes faster. And I don't think about the fact that I'm here. You know, that I have to be here. Then I do something I actually want to do and look forward to. So I do look forward to those days.

Discussion

From the patients' genuine and detailed accounts, we found that the stable provided a context where they were able to construct a positive self, namely one that is necessary, is accepted, and can cope with challenges and achieve: or more fundamentally, a self that is different from the "patient" receiving treatment for a problem or disease. As such, HAT appears to be more than just a break from treatment as usual.

Participants generally presented their time spent in the stable as a consistently positive and different experience, which they looked forward to. Having something pleasant and active to look forward to gave a sense of structure and endurance to their experience, which they seemed to contrast to an otherwise negatively connoted mere "existence" in treatment.

Throughout participants' accounts, the stable is constructed as a context where they experience different versions of themselves: where, in addition to enjoyment, they felt responsible and necessary, and achieved and contributed to something. By perceiving themselves as someone who could contribute to, or achieve, something useful in the stable context, they were able to draw a positive contrast between themselves "as I am" with their concept of themselves as a "patient" or "drug addict" – a problem. In this, there is an implicit acknowledgment of the social and emotional geography of the stable.[44]

A social constructionist view of the participants' experience of HAT implies exploration of the meanings they made of HAT and its role, as well as their own role as a patient undergoing treatment. These meanings and experiences are part of the treatment process because they are experienced as characteristic of the social and emotional geography experienced in the stable and as characteristic of the social reality of undergoing treatment. The participants' descriptions and reflections shed light on HAT in the context of SUD treatment with implications for inclusion of this type of adjunct therapy in SUD treatment. Perhaps, more importantly, they appear to indicate issues of more general relevance to addiction treatment, which merit further investigation.

Emotional geography sheds light on how emotions may construct and be constructed in relation to physical locations.[57] Together with the SUD's socio-historical context, social geography offers interesting perspectives on the relevance of the stable's environmental context in the participants' accounts. They communicated an implicit understanding of HAT as learning to interact with the social environment through interaction with the horse, with the HAT staff, and with others in the stable. Their shared meanings seem to indicate participants' sense of belonging and their identification with this stable-based SUD treatment program.

The socio-historical context. The socio-historical context, such as Norwegian policy on illegal drugs, provides a crucial context for understanding the social environment of our participants. They belong to a group long regarded in Norwegian society as a problem. As Skretting says: "Norway seems to have developed a "schizophrenic" view of the drug problem. On the one hand, the health aspects of drug abuse are increasingly central to thinking, while on the other (hand) penalties for drug offenses remain high."[58(p. 569)]

Discourse has implications for both subjectivity and experience.[59] Criminal discourse has categorized persons with addiction as a problem, and as a possible danger to society and not to be trusted. In biomedical discourse, addiction is a disease that positions "the patient" as a passive recipient of expert care. Discourses legitimate and reinforce existing social and institutional structures at the same time, as these structures support and validate the discourses. In this respect there are anomalies or contradictory requirements of a person suffering from SUD. The concept of the criminal designates a person who cannot be trusted in society, yet trust has been identified as a significant threshold for SUD treatment. The concept of the "patient" reflects a passive receiver of treatment, while, at the same time, SUD treatment is based on a requirement of the "patient's" active willingness to "being cured".

The stable context. Throughout the participants' accounts, the stable was represented as an "independent" environment, an environment that existed "anyway" and on its own accord, and not necessarily related to what happened at "Huset/the house" or in the rest of the world. Cylwik suggests that "place in a physical sense does not produce emotions but rather it is the way that people, as individuals and groups, culturally and socially construct place and give it meaning that produces emotions".[42(p. 244)] The stable was presented as a place where the participants could interact differently: a place where the activities and work associated with the horses shaped their social interaction and emotional meaning making.

This is relevant for a number of reasons. Many participants expressed the view that the horse saw them for "who you really are" and often "mirrored" their behavior.[26] The HAT

team only saw the patients in the stable, with the horses whose reaction to participants was reportedly perceived as based largely on the behavior the participants displayed in the present. In addition, the HAT team had a stated policy of treating participants based on their behavior in the stable, rather than as based on diagnosis or knowledge of their previous life. The way the participants acted in the stable was typically described by themselves as different and in more positive terms than their behavior outside the stable. Thus, the horses and the HAT team were perceived by the participants as recognizing a version of them that they themselves described as positive.

The patient–staff context. Skatvedt and Schou[8] point to the prevalence of asymmetrical client–staff relations in SUD treatment, but observed that pauses from the formalized treatment setting, such as taking a smoke together, often served to equalize the clients' experience of the asymmetry. They demonstrate the impact of different manifestations of the "us" (clients) and "them" (staff) relationships in SUD treatment. They point to the importance of "straight" identity and reciprocity in relationships as enablers of an identity. Skatvedt reports:

> residents repeatedly identify themselves as something more than drug abusers in specific interaction situations, in contrast to who they were in most other situations. It was this former category of situation that they identified as giving them motivation to keep moving towards a more positive future.[8(p. 85)]

The participants in the present study rarely described other treatment staff explicitly. However, by distinguishing the HAT team from the general "huset/the house" team, they communicated effectively how their experience of being in the stable differed from their experience of usual SUD treatment. Moreover, the HAT team was frequently described as "friends" or "really nice girls", without the connotations of asymmetry that are often experienced in client–staff relations.[8] Or, as P.5 said of the stable staff, they don't "treat us like we were inferior."

The participants' experience in the stable of being seen as who they believed they really were, rather than as drug addicts or patients, suggests possible recognition issues that need to be addressed in the broader treatment system. The relevance of this is illustrated in stories where marginalized young people refer to the milestones of their life as being persons who recognized and appreciated them for exactly what and who they were.[60]

Studies of SUD and identity report patients' and prisoners' own distinction between their SUD identity and their real self.[61–64] These, however, are accounts of how the patient/prisoner saw him/herself, or how others responded to the addict-self. They contain no mention of the *real self* as being *recognized* by therapists or others. We found no literature specifically connecting SUD and recognition theory, but note that Taylor refers to recognition as "a vital human need".[41(p. 26)] He linked recognition to identity, which he described as "a person's understanding of who they are, of their fundamental characteristics as a human being".[41] It is possible that the recognition of their "real self," which our participants described as occurring in the stable, met a basic need. In so doing, it may have enhanced both their own self-image and their identification with HAT as a positive SUD treatment program. The interrelationship of recognition, identity, and program identification in SUD treatment and retention appears to warrant further investigation in a variety of treatment settings.

The activity context. The participants communicated a sense of pleasure and achievement from engaging in activity which they saw as "doing something useful" as well as enjoyable in the stable. The feelings of responsibility and contribution derived from these activities provided them with a sense of meaning. Other qualitative studies of SUD treatment draw attention to the importance of activity but from differing perspectives. Participants in Nordheim et al's study[28] at the same institution emphasized the physical benefits of the exercise associated with their stable work, as did Burgon in her study of adults engaged in horse-riding therapy.[53] Neale et al, in a study of 40 heroin users, found physical activity, sport, and exercise to be perceived as pleasurable and as contributing to health and social gains as well as reduced heroine use,[65] and Decker et al suggest that participants' productive engagement in meaningful and enjoyable hobby activities may explain their reduced irregular discharge.[11]

Some will argue that therapy should not necessarily be pleasant always. However, these participants' accounts suggest that the positive emotions they experienced in the stable may in fact be a motivational factor for both retention and investment in treatment. The very fact that all participants stated that they looked forward to HAT, and some even explicitly claimed it to be the highlight of their week, is a sentiment to the importance they placed on this therapy. No therapist, no matter how skilled or involved, can help a person who is not motivated to change.

Consistent with the finding of Nettleton et al in their discourses of normality[66] and Decker et al in their hobbies study,[11] our participants' understanding of the therapeutic meaning of HAT may have been enhanced precisely because HAT was experienced more as an enjoyable "normal" activity rather than as traditional therapy in a SUD treatment setting.

Methodological considerations. Our findings are derived from a naturalistic study that used translated data from a small number of participants to explore their specific experience within a specific context. Transferability to other settings cannot be assumed. Nor are we suggesting that HAT alone facilitated emotional participation. There are obviously many other factors, such as patient–therapist alliance or group therapy, that can influence emotions and engagement in SUD therapy.

However, the findings relating to relations in the stable with staff, other clients/patients, and horses are consistent with

those in the HAT literature.[16,29] Similarly, findings relating to positive affect, feeling productive, and appreciated are also consistent with those in the small number of relevant studies of SUD patients' own perspective of therapy.[11,28] In addition, the natural and positive reinforcement, which patients describe as associated with the stable's positive social, emotional and communicative geography, resonates with Miller's concept of a "much larger social-environmental context" as motivational.[5(p. 140)] They are consistent with other studies showing the importance of contextual factors in SUD treatment.[67]

There are some obvious but unavoidable shortcomings. Therapy involving horses is a new, rapidly developing area of psychotherapy, which is relatively unknown in the health sector. When reported, it is usually from the provider's or researcher's perspective. The patients' own perspectives of therapy need to be better understood[7,68] and in their own words.[8] This is the reasoning behind our extensive use of illustrative quotations derived from the data. Although our findings were discussed in detail with HAT patients and staff, and are generally consistent with the sparse available literature, it is regrettable that no other measures by which we could triangulate our findings were available.

Interpretation is a challenge common to most qualitative studies, particularly cross-language studies. The first author was aware of a certain dependence on the second author for nuanced meanings throughout the study process. However, she and the other authors believe that the timing and process of translation, and retranslation by an independent person fluent in both Norwegian and English who was also very familiar with the drug therapy scene and language, best protected representation of the participants' views in their own words.

Patients' insights, and accounts of those insights, can be influenced by many other factors including the social context of the experience and researchers' interpretations of the insights.[31,32] Although the third and fourth authors provided a certain counterbalance, the two first authors' pro-horse backgrounds undoubtedly influenced the interviews, as well as the study process, interpretations, and outcomes, despite their best attempts to share and bracket preconceptions. In a similar fashion, the first author's extensive career in health policy and management has no doubt influenced the issues discussed and the study conclusions.

We have not discussed the relevance of the horse per se or its role in the findings presented in this paper. Throughout the study, the first two authors constantly debated whether similar findings could be obtained if another animal (such as a dog) or another productive activity (such as gardening) were substituted. These debates generally concluded that the horse was central for reasons previously reported[26] but that the horse(s) alone could not produce the outcome reported here. The physical, social, and emotional context associated with the stable environment was also an essential element in the therapeutic process.

The above should not deter serious consideration of the potentially important findings for SUD service providers. Their validity, significance, and transferability need to be addressed in further studies.

Implications. This study has obvious implications for those interested in HAT. However, there would also appear to be more important implications on the broader level of SUD policy, treatment, and research, which may have little or even nothing to do with HAT per se.

Participants' self-perception of being a "person" in the stable, in contrast to being a "patient" in their usual treatment location, is, we believe, the most significant finding from this study – one previously unreported in the scientific literature as far as we are aware. The possible relationship of this finding to aspects of recognition theory is noted with the suggestion that it should be explored further. Similarly, this finding calls for exploration in other settings of how the physical, social, and emotional geography of the therapeutic landscape may facilitate patients' identification with the treatment program and encourage a positive self-concept, thereby enabling them to be, and to be seen as, a person in treatment rather than as a patient.

As most addiction treatment programs struggle to find means of combating high dropout rates, it is important to test factors that patients themselves identify as making treatment more endurable and/or facilitating retention. This study indicates the value of including SUD patients' own perspectives expressed in their own terms in investigative research.

Conclusion

In the present study, the stable was portrayed as a context where the participants were able to construct a positive self, namely one that is necessary, is accepted, can cope with challenges, and be achieved: more fundamentally, a self that is different from the "patient" receiving treatment for a problem or disease. The underlying theme "break from usual treatment" indicates the significance of the specific socio-historical context within SUD treatment for these participants' self-constructs and experiences, but it appears to under-represent the importance of the findings for general SUD treatment development. The implications extend well beyond HAT and the stable environment.

Acknowledgments

We thank the participants for sharing their views, the Lions Clubs of Oslo and Slemdal for the horses, Oslo University Hospital stable therapists and support staff for their cooperation, Ulleval Medical Library, Oslo University Hospital, for assistance with the literature review, and Rita Berget for translation assistance.

Author Contributions

Reviewed relevant literature, conceived the study, and (with IHB) designed the study: AKG. Conducted, transcribed, and carried out the initial analysis of the interviews: IHB. Reviewed and analyzed the transcripts: AKG, IHB. Drafted the manuscript (with input from IHB) AKG. Critically

reviewed the manuscript: ER, EA. All authors approved the final submitted version.

REFERENCES

1. Brorson HH, Ajo Arnevik E, Rand-Hendriksen K, Duckert F. Drop-out from addiction treatment: a systematic review of risk factors. *Clin Psychol Rev*. 2013;33(8):1010–24.
2. Ravndal E, Vaglum P, Lauritzen G. Completion of long-term inpatient treatment of drug abusers: a prospective study from 13 different units. *Eur Addict Res*. 2005;11(4):180–5.
3. Simpson DD. Modeling treatment process and outcomes. *Addiction*. 2001;96(2): 207–11.
4. Ravndal E, Vaglum P. Why do drug abusers leave the therapeutic community? Problems with attachment and identification in a hierarchical treatment community. *Nordic J Psychiatry*. 1994;48(s33):4–55.
5. Miller WR. Motivational factors in addictive behaviors. In: William WR, Carroll KM, eds. *Rethinking Substance Abuse: What the Science Shows, and What We Should Do about It*. New York: The Guilford Press; 2006:134–50.
6. Miller WR, Moyers TB. The forest and the trees: relational and specific factors in addiction treatment. *Addiction*. 2014;110:401–13.
7. Neale J. Drug users' views of drug service providers. *Health Soc Care Community*. 1998;6(5):308–17.
8. Skatvedt A, Schou KC. The potential of the commonplace: a sociological study of emotions, identity and therapeutic change. *Scand J Public Health*. 2010;38(5 suppl):81–7.
9. Molin J, Graneheim UH, Lindgren BM. Quality of interactions influences everyday life in psychiatric inpatient care-patients' perspectives. *Int J Qual Stud Health Well-being*. 2016;11:29897.
10. Blacher S, Rundio A. Complementary and integrative modalities in addiction treatment. *J Addict Nurs*. 2014;25(4):165–6.
11. Decker KP, Peglow SL, Samples CR. Participation in a novel treatment component during residential substance use treatment is associated with improved outcome: a pilot study. *Addict Sci Clin Pract*. 2014;9:7.
12. Hallberg L. *Walking the Way of the Horse. Exploring the Power of the Horse-Human Relationship*. Bloomington: iUniverse; 2008.
13. Bachi K. Application of attachment theory to equine-facilitated psychotherapy. *J Contemp Psychother*. 2013;43(3):187–96.
14. Scheidhacker M. The horse – real relational object and achetypal symbol. In: DKfTR, ed. *Therapeutic Riding in Germany: Selected Contributions*. Warendorf: DKThR; 1998;107–10.
15. Yrjölä ML. The horse as a good object in long term psychotherapy. In: Reiten FAmdPidPDKfT, ed. *Equine Fascilitated Psychotherapy*. Warendorf: FNverlag der Deutschen Reiterlichen Vereinigung GmbH; 2009:122–33.
16. Burgon H. *Equine-Assisted Therapy and Learning with At-Risk Young People*. London: Palgrave Macmillan; 2014.
17. Johansen SG, Arfwedson Wang CE, Binder P-E, Malt UF. Equine-facilitated body and emotion-oriented psychotherapy designed for adolescents and adults not responding to mainstream treatment: a structured program. *J Psychother Integr*. 2014;24(4):323.
18. Shambo L, Young D, Madera C. *The Listening Heart. The Limbic Path Beyond Office Therapy*. Bishop, CA: Human-Equine Alliance for Learning (HEAL); 2013.
19. Karol J. Applying a traditional individual psychotherapy model to equine-facilitated psychotherapy (EFP): theory and method. *Clin Child Psychol Psychiatry*. 2007;12(1):77–90.
20. Anestis MD, Anestis JC, Zawilinski LL, Hopkins TA, Lilienfeld SO. Equine-related treatments for mental disorders lack empirical support: a systematic review of empirical investigations. *J Clin Psychol*. 2014;70(12):1115–32.
21. Bachi K. Equine-facilitated psychotherapy: the gap between practice and knowledge. *Soc Anim*. 2012;20(4):364–80.
22. Lee PT, Dakin E, McLure M. Narrative synthesis of equine-assisted psychotherapy literature: current knowledge and future research directions. *Health Soc Care Community*. 2016;24(3):225–46.
23. Lentini JA, Knox MS. Equine-facilitated psychotherapy with children and adolescents: an update and literature review. *J Creativity Mental Health*. 2015;10(3):278–305.
24. Kern-Godal A. Riding out of addiction. *FRDI Newslett*. 2013;2:2–7.
25. Kern-Godal A, Arnevik E, Walderhaug E, Ravndal E. Substance use disorder treatment retention and completion: a prospective study of horse-assisted therapy (HAT) for young adults. *Addict Sci Clin Pract*. 2015;10(1):1–12.
26. Kern-Godal A, Brenna IH, Kogstad N, Arnevik EA, Ravndal E. Contribution of the patient-horse relationship to substance use disorder treatment: patients' experiences. *Int J Qual Stud Health Well-being*. 2016;11:31636.
27. Flores PJ. Conflict and repair in addiction treatment: an attachment disorder perspective. *J Groups Addict Recover*. 2006;1(1):5–26.
28. Nordheim K, Walderhaug E, Alstadius S, Kern-Godal A, Arnevik E, Duckert F. Young adults' reasons for dropout from residential substance use disorder treatment. *Qualitative Social Work*, 1473325016654559, first published on June 16, 2016.
29. Carlsson C, Ranta Nilsson D, Traeen B. Equine assisted social work as a mean for authentic relations between clients and staff. *Human-Animal Interact Bull*. 2014;2(1):19–38.
30. Skårderud F, Sommerfeldt B. *Miljøterapiboken. Mentalisering som holding og handling (Minding the milieu. Mentalization based practice)*. Oslo: Gyldendal akademisk; 2013.
31. Patton MQ. *Qualitative Evaluation and Research Methods*. 4ed ed. SAGE Publications, Thousand Oaks, CA: Sage, Inc; 2015.
32. Malterud K. Qualitative research: standards, challenges, and guidelines. *Lancet*. 2001;358(9280):483–8.
33. Lancaster K, Ritter A. Examining the construction and representation of drugs as a policy problem in Australia's National Drug Strategy documents 1985–2010. *Int J Drug Policy*. 2014;25(1):81–7.
34. Lancaster K. Social construction and the evidence-based drug policy endeavour. *Int J Drug Policy*. 2014;25(5):948–51.
35. Burr V. *An Introduction to Social Constructionism*. London, New York, NY: Routledge; 1995.
36. Neale J, Allen D, Coombes L. Qualitative research methods within the addictions. *Addiction*. 2005;100(11):1584–93.
37. Neale J, West R. Guidance for reporting qualitative manuscripts. *Addiction*. 2015;110(4):549–50.
38. Cromby J, Nightingale DJ. What's wrong with social constructionism? In: Nightingale DJ, Cromby J, eds. *Social Constructionist Psychology: A Critical Analysis of Theory and Practice*. Buckingham: Open University Press; 1999:1–20.
39. Fletcher AJ. Applying critical realism in qualitative research: methodology meets method. *Int J Soc Res Methodol*. 2016;19:1–14.
40. Honneth A. *The Struggle for Recognition: The Moral grammar of Social Conflicts*. Cambridge, MA: MIT Press; 1995:1992.
41. Taylor C. The Politics of Recognition. In: Gutmann A, ed. *Multiculturalism: Examining the Politics of Recognition*. Princeton: Princeton University Press; 1992:25–73.
42. Cylwik H. Notes from the field: emotions of place in the production and interpretation of text. *Int J Soc Res Methodol*. 2001;4(3):243–50.
43. Anderson K, Smith SJ. Editorial: emotional geographies. *Trans Inst Br Geogr*. 2001;26(1):7–10.
44. Bondi L. Making connections and thinking through emotions: between geography and psychotherapy. *Trans Inst Br Geogr*. 2005;30(4):433–48.
45. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(2):77–101.
46. Brenna IH. *"They are Part of What Made My Treatment Positive. And Maybe More Meaningful.": Participants' Experience of Horse-Assisted Therapy in Addiction Treatment*. Oslo: Psychology, University of Oslo; 2013.
47. Braun V, Clarke V. What can "thematic analysis" offer health and wellbeing researchers? *Int J Qual Stud Health Well-being*. 2014;9:26152. doi: 10.3402/qhw.v9.26152.
48. Squires A. Methodological challenges in cross-language qualitative research: a research review. *Int J Nurs Stud*. 2009;46(2):277–87.
49. Santos HP, Black AM, Sandelowski M. Timing of translation in cross-language qualitative research. *Qual Health Res*. 2015;25(1):134–44.
50. Dahle KA, Iversen HH. In: Nasjonalt kunnskapssenter for helsetjenesten, ed. *Hva er viktig for pasienter innen rusbehandling? Notat fra Kunnskapssenteret. (What is Important for Patients in Substance Abuse Treatment? Note from the Norwegian Knowledge Centre for Health Services)*. Nasjonalt kunnskapssenter for helsetjenesten: Oslo; 2011.
51. Haugum MHO, Iversen HH, Bjertnæs ØA. Pasienterfaringer med døgnopphold innen tverrfaglig spesialisert rusbehandling (TSB). Resultater etter en nasjonal undersøkelse i 2015 (Inpatients' experiences with interdisciplinary treatment for substance dependence, Results after a national survey in 2015). In: Folkehelseinstituttet, ed. *PasOpp-rapport* 2016. Vol 1. Oslo: Folkehelseinstituttet; 2015.
52. Bachi, Keren, "An Equine-Facilitated Prison-Based Program: Human-Horse Relations And Effects On Inmate Emotions And Behaviors" (2014). *All Dissertations, Theses, and Capstone Projects (2014-Present)*. Paper 162.
53. Burgon H. Case studies of adults receiving horse-riding therapy. *Anthrozoos*. 2003;16(3):263–76.
54. Fry NE. Equine-assisted therapy: an overview. In: Grassberger MSR, Gileva OS, Kim CMH, Mumcuoglu KY, eds. *Biotherapy-History, Principles and Practice: A Practical Guide to the Diagnosis and Treatment of Disease Using Living Organisms*. Dordrecht, Netherlands: Springer; 2013:255–84.
55. Hamilton A. *Zen Mind Zen Horse: the Science and Spirituality of Working with Horses*. Mass: Storey Publishing; 2011.
56. Kohanov L. *The Power of the Herd: A Nonpredatory Approach to Social Intelligence, Leadership and Innovation*. Novato, CA: New World Library; 2013.
57. Davidson J, Milligan C. Embodying emotion sensing space: introducing emotional geographies. *Soc Cultural Geogr*. 2004;5(4):523–32.
58. Skretting A. Governmental conceptions of the drug problem: a review of Norwegian governmental papers 1965–2012. *Nordic Stud Alcohol Drugs*. 2014;31:569.
59. Willig C. A discourse-dynamic approach to the study of subjectivity in health psychology. *Theory Psychol*. 2000;10(4):547–70.

60. Lie GT, Granby I. *Mennesket bak rusen: om Selbukollektivets historie, ungdommenes utviklingsprosess og betydningen av anerkjennelse. (The Person behind the Addiction: About the Selbu Collective's History, the Development Process of the Youth and the Importance of Recognition)*. Bergen: Fagbokforlaget; 2011.
61. Best D, Beckwith M, Haslam C, et al. Overcoming alcohol and other drug addiction as a process of social identity transition: the social identity model of recovery (SIMOR). *Addict Res Theory*. 2016;24(2):111–23.
62. McIntosh J, McKeganey N. Addicts' narratives of recovery from drug use: constructing a non-addict identity. *Soc Sci Med*. 2000;50(10):1501–10.
63. Johansen AB, Brendryen H, Darnell FJ, Wennesland DK. Practical support aids addiction recovery: the positive identity model of change. *BMC Psychiatry*. 2013;13(1):1–11.
64. Kilty J. Tensions within identity: notes on how criminalized women negotiate identity through addiction. *Aporia*. 2011;3(3):5–15.
65. Neale J, Nettleton S, Pickering L. Heroin users' views and experiences of physical activity, sport and exercise. *Int J Drug Policy*. 2012;23(2):120–7.
66. Nettleton S, Neale J, Pickering L. 'I just want to be normal': an analysis of discourses of normality among recovering heroin users. *Health*. 2013;17(2):174–90.
67. Polcin DL, Mulia N, Jones L. Substance users' perspectives on helpful and unhelpful confrontation: implications for recovery. *J Psychoact Drugs*. 2012;44(2):144–52.
68. Thornicroft G, Mehta N, Clement S, et al. Evidence for effective interventions to reduce mental-health-related stigma and discrimination. *Lancet*. 2016;387(10023):1123–32.