TECHNICAL COMMENTARY

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Animal-assisted therapy

Introduction

Animal-assisted interventions use trained animals to help improve physical, mental and social functions in people with schizophrenia. It is a goal-directed intervention in which an animal that meets specific criteria is an integral part of the treatment process, which usually involves pharmaceutical and psychosocial treatment components. It has been shown to improve outcomes for people with autism-spectrum symptoms, medical difficulties, and behavioural problems.

Method

We have included only systematic reviews (systematic literature search, detailed methodology with inclusion/exclusion criteria) published in full text, in English, from the year 2000 that report results separately for people with a diagnosis of schizophrenia, schizoaffective disorder, schizophreniform disorder or first episode schizophrenia. Due to the high volume of systematic reviews we have now limited inclusion to systematic meta-analyses. Where no systematic meta-analysis exists for a topic, systematic reviews without meta-analysis are included for that topic. Reviews were identified by searching the databases MEDLINE, EMBASE, CINAHL, Current Contents, PsycINFO and the Cochrane library. When multiple copies of reviews were found, only the most recent version was included. Reviews with pooled data are prioritised for inclusion.

Review reporting assessment was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist that describes a preferred way to present a meta-analysis[1].

Reviews reporting less than 50% of items have been excluded from the library. The PRISMA flow diagram is a suggested way of providing information about studies included and excluded with reasons for exclusion. Where no flow diagram has been presented by individual reviews, but identified studies have been described in the text, reviews have been checked for this item. Note that early reviews may have been guided by less stringent reporting checklists than the PRISMA, and that some reviews may have been limited by journal guidelines.

Evidence was graded using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group approach where high quality evidence such as that gained from randomised controlled trials (RCTs) may be downgraded to moderate or low if review and study quality is limited, if there is inconsistency in results, indirect comparisons, imprecise or sparse data and high probability of reporting bias. It may also be downgraded if risks associated with the intervention or other matter under review are high. Conversely, low quality evidence such as that gained from observational studies may be upgraded if effect sizes are large or if there is a dose dependent response. We have also taken into account sample size and whether results are consistent, precise and direct with low associated risks (see end of table for an explanation of these terms)[2]. The resulting table represents an objective summary of the available evidence, although the conclusions are solely the opinion of staff of NeuRA (Neuroscience Research Australia).

Results

We found two systematic reviews that met inclusion criteria[3, 4].

- Moderate to low quality evidence suggests animal-assisted therapy may improve social functioning, symptoms, treatment adherence, self-esteem, and self-determination.

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Kamioka H, Okada S, Tsutani K, Park H, Okuizumi H, Handa S, Oshio T, Park S, Kitayuguchi J, Abe T, Honda T, Mutoh Y

Effectiveness of animal-assisted therapy: A systematic review of randomized controlled trials

Complementary Therapies in Medicine 2014; 22: 371-390

View review abstract online

Comparison	**2-3 months of weekly or twice weekly 45 minute to 1 hour sessions using dogs or cats vs. treatment as usual.**
Summary of evidence	**Moderate to low quality evidence (small samples, unable to assess consistency or precision, direct) suggests animal-assisted therapy (dog or cat) may improve social functioning in people with schizophrenia.**
3 small randomised controlled trials (RCTs), total N = 67, all reported improvements in inpatients. 1 RCT reported the dog intervention group showed significant improvements in living skills and social contacts, with no differences between groups for positive or negative symptom severity. 1 RCT of chronic inpatients reported the dog or cat intervention group showed significant improvements in social adaptive functioning compared to controls. 1 RCT reported the dog treatment group showed significantly improved self-esteem, self-determination, and positive psychiatric symptoms compared to controls. No differences were reported for extent of social support or negative psychiatric symptoms.	
Consistency in results‡	No measure of consistency is reported
Precision in results§	No measure of consistency is reported
Directness of results‖	Direct

Hawkins EL, Hawkins RD, Dennis M, Williams JM, Lawrie SM

Animal-assisted therapy for schizophrenia and related disorders: A systematic review

Journal of Psychiatric Research 2019; 115: 51-60

View review abstract online

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Comparison	**Animal assisted therapies vs. mixed control conditions.**
Summary of evidence	**Moderate to low quality evidence (small samples, unable to assess consistency or precision, direct) suggests animal-assisted therapy may improve social functioning, symptoms, treatment adherence, self-esteem, and self-determination.**
1 RCT (N = 20) compared 12 months of animal assisted therapy (dogs and cats) to reading and discussion of current news and reported improvements in social functioning. 1 RCT (N = 69) compared 12 weeks of animal assisted therapy (farm animals) to treatment as usual and reported improvements in anxiety and self-efficacy. No differences were found for quality of life, coping strategies, or depression. 1 RCT (N = 22) compared 6 months of animal assisted therapy (dogs) to treatment as usual plus activity from a functioning program and reported improvements in adherence and cortisol levels. No differences were found for symptoms or quality of life. 1 RCT (N = 27) compared 2 months of animal assisted therapy (dogs) to treatment as usual and reported improvements in positive symptoms, emotional symptoms, self-esteem, and self-determination. No differences were found for negative symptoms or social support. 1 RCT (N = 100) compared 2 months of pet therapy (hamsters) and reported improvements in negative symptoms. 1 RCT (N = 90) compared 10 weeks of equine- or canine-assisted psychotherapy (horses and dogs) to social skills exercises and regular hospital care and reported less violent incident reports. No differences were found for symptoms, pet attitudes, life skills, or intrusive thoughts. 1 RCT (N = 18) compared 12.5 weeks of animal assisted therapy (dogs) to any other novel intervention and reported no differences were found for symptoms, quality of life, or life skills.	
Consistency in results	No measure of consistency is reported
Precision in results	No measure of consistency is reported
Directness of results	Direct

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Explanation of technical terms

* Bias has the potential to affect reviews of both RCT and observational studies. Forms of bias include; reporting bias – selective reporting of results; publication bias - trials that are not formally published tend to show less effect than published trials, further if there are statistically significant differences between groups in a trial, these trial results tend to get published before those of trials without significant differences; language bias – only including English language reports; funding bias - source of funding for the primary research with selective reporting of results within primary studies; outcome variable selection bias; database bias - including reports from some databases and not others; citation bias - preferential citation of authors. Trials can also be subject to bias when evaluators are not blind to treatment condition and selection bias of participants if trial samples are small[5].

† Different effect measures are reported by different reviews.

Prevalence refers to how many existing cases there are at a particular point in time. Incidence refers to how many new cases there are per population in a specified time period. Incidence is usually reported as the number of new cases per 100,000 people per year. Alternatively some studies present the number of new cases that have accumulated over several years against a person-years denominator. This denominator is the sum of individual units of time that the persons in the population are at risk of becoming a case. It takes into account the size of the underlying population sample and its age structure over the duration of observation.

Reliability and validity refers to how accurate the instrument is. Sensitivity is the proportion of actual positives that are correctly identified (100% sensitivity = correct identification of all actual positives) and specificity is the proportion of negatives that are correctly identified (100% specificity = not identifying anyone as positive if they are truly not).

Mean difference scores refer to mean differences between treatment and comparison groups after treatment (or occasionally pre to post treatment) and in a randomised trial there is an assumption that both groups are comparable on this measure prior to treatment. Standardised mean differences are divided by the pooled standard deviation (or the standard deviation of one group when groups are homogenous) that allows results from different scales to be combined and compared. Each study's mean difference is then given a weighting depending on the size of the sample and the variability in the data. Less than 0.4 represents a small effect, around 0.5 a medium effect, and over 0.8 represents a large effect[5].

Odds ratio (OR) or relative risk (RR) refers to the probability of a reduction (< 1) or an increase (> 1) in a particular outcome in a treatment group, or a group exposed to a risk factor, relative to the comparison group. For example, a RR of 0.75 translates to a reduction in risk of an outcome of 25% relative to those not receiving the treatment or not exposed to the risk factor. Conversely, a RR of 1.25 translates to an increased risk of 25% relative to those not receiving treatment or not having been exposed to a risk factor. A RR or OR of 1.00 means there is no difference between groups. A medium effect is considered if RR > 2 or < 0.5 and a large effect if RR > 5 or < 0.2[6]. lnOR stands for logarithmic OR where a lnOR of 0 shows no difference between groups. Hazard ratios

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measure the effect of an explanatory variable on the hazard or risk of an event.

Correlation coefficients (eg, r) indicate the strength of association or relationship between variables. They can provide an indirect indication of prediction, but do not confirm causality due to possible and often unforseen confounding variables. An r of 0.10 represents a weak association, 0.25 a medium association and 0.40 and over represents a strong association. Unstandardised (*b*) regression coefficients indicate the average change in the dependent variable associated with a 1 unit change in the independent variable, statistically controlling for the other independent variables. Standardised regression coefficients represent the change being in units of standard deviations to allow comparison across different scales.

‡ Inconsistency refers to differing estimates of effect across studies (i.e. heterogeneity or variability in results) that is not explained by subgroup analyses and therefore reduces confidence in the effect estimate. I^2 is the percentage of the variability in effect estimates that is due to heterogeneity rather than sampling error (chance) - 0% to 40%: heterogeneity might not be important, 30% to 60%: may represent moderate heterogeneity, 50% to 90%: may represent considerable heterogeneity and over this is considerable heterogeneity. I^2 can be calculated from Q (chi-square) for the test of heterogeneity with the following formula[5];

$$I^2 = \left(\frac{Q - df}{Q}\right) \times 100\%$$

§ Imprecision refers to wide confidence intervals indicating a lack of confidence in the effect estimate. Based on GRADE recommendations, a result for continuous data (standardised mean differences, not weighted mean differences) is considered imprecise if the upper or lower confidence limit crosses an effect size of 0.5 in either direction, and for binary and correlation data, an effect size of 0.25. GRADE also recommends downgrading the evidence when sample size is smaller than 300 (for binary data) and 400 (for continuous data), although for some topics, these criteria should be relaxed[7].

‖ Indirectness of comparison occurs when a comparison of intervention A versus B is not available but A was compared with C and B was compared with C that allows indirect comparisons of the magnitude of effect of A versus B. Indirectness of population, comparator and/or outcome can also occur when the available evidence regarding a particular population, intervention, comparator, or outcome is not available and is therefore inferred from available evidence. These inferred treatment effect sizes are of lower quality than those gained from head-to-head comparisons of A and B.

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