Understanding Behavior

About This Column

Behavior problems are a significant cause of death (euthanasia) in companion animals. While most veterinary practices are necessarily geared toward the medical aspect of care, there are many opportunities to bring behavior awareness into the clinic for the benefit of the pet, the owner, and ourselves. This column acknowledges the importance of behavior as part of veterinary medicine and speaks practically about using it effectively in daily practice.

Behavior Assessment: Completing the Examination

Sharon L. Crowell-Davis, DVM, PhD, DACVB,* The University of Georgia

The first two articles in this series on assessing behavior patients explored the use of history forms and owner interviews to gather information about history, environment, other problems, and owner commitment to treatment. This article addresses direct observation and evaluation of the patient, including interaction with the owner, veterinary staff, and other pets.

To understand the relationship between a behavior patient and its owner, comprehensive information about any prior training the patient has received and the degree to which the owner can affect the pet’s behavior through verbal commands is critical. This information is often also important in understanding the development of behavior problems, particularly for dogs. Although most dogs undergo some degree of obedience training, the amount and level of that training can vary widely, from a few sessions conducted by the owner based on tips from a book, DVD, or TV show to many hours of formal training conducted or supervised by a professional.

As with many other issues of pet behavior, such as getting “mad,” clear, explicit descriptions are essential to knowing exactly how the animal was trained. If the owners state that positive reinforcement was used, ask exactly what type of positive reinforcement and when. For example, food treats may have been unsuccessful either because they were not sufficiently palatable (e.g., dry kibble) or because they were so highly palatable that the pet became extremely excited, resulting in a decreased response to training. Likewise, owners may say that aversive training techniques or punishment were not used because a trainer they consulted told them that leash corrections involving jerking a choke chain against the trachea did not hurt.

QuickNotes

Detailed, specific information about the patient’s training history should be obtained.
Sometimes dogs that have been trained using strictly positive reinforcement techniques and are calm during training act very fearful during unstructured interactions with their owners. This is because, in the structured training situation, the owner's behavior is more predictable and reliable for the dog, whereas during unstructured interactions the dog may be unsure of what the owner is going to do. For a fearful dog, uncertainty about what is going to happen can exacerbate both fear and aggression.

If a pet knows how to do a trick on command, the reliability of the interaction during the trick may be useful in treating a variety of behavior problems. For example, one dog with fear aggression that presented to my office only relaxed and exhibited body language indicative of a nonfearful state when family members asked it to “high five” by holding their hand, palm forward, near the dog while saying that phrase. The dog would then raise its paw to touch the hand. All other attempts by family members to initiate interaction with the dog resulted in the dog exhibiting various signs of fear, including laying its ears back against its head, lowering its head and/or tail, growling, and occasionally snapping or biting. During early phases of treatment for the fear aggression, frequent requests to “high five” were used to increase the amount of positive interaction between the dog and the family.

**Observing the Patient in the Office**

Much can be learned by directly observing the patient during the owner interview, while the attention of all the people in the room is superficially directed to each other. For example, cats are typically brought to the clinic in carriers. I usually ask the client to set the carrier on the floor with the door open. Because the veterinarian’s office is a strange and intimidating place, many cats remain in the carrier. Over a period of minutes, some gradually stick their nose out, then their head, and finally exit the carrier very cautiously. A few bolder cats come out more rapidly. Whether and how the cat leaves the carrier is useful information for identifying how timid or bold the animal is. Allowing the cat to leave the security of the carrier when it is ready to also gives it the opportunity to gradually familiarize itself with the room.

If two or more cats are presented for fighting at home, observing how they freely interact in the veterinary office can sometimes be useful; however, it is usually helpful to obtain the owner’s opinion on the advisability of this approach. If the owner believes that the cats fight only under very specific circumstances that are unlikely to be replicated in the veterinarian’s office, useful information can be obtained by letting the cats out in the office and observing how they signal each other— which one stares and which one looks away; which one walks boldly across the middle of the room and which one hides in a corner or under a chair; which one holds its ears stiffly upright and rotated to the side and which one tucks its ears back against its head. However, if the owner has any concern that the cats might fight in the office, it is best not to let them interact directly.

Dogs that are brought in for evaluation should initially be kept on leash and, if there is a history of aggression, in a basket muzzle. If the history does not indicate any background of aggressiveness or excessive fear of strangers, 2 or 3 minutes of observing the dog’s demeanor while on leash in the examination room should be sufficient to verify whether it is safe for the dog to be allowed loose. Allowing the dog to explore the room and people in it is desirable, if it is safe. While the dog is off leash in the examination room, the clinician and staff can develop a rapport with the dog by giving it treats. If the history indicates that the dog should know the correct responses to basic commands (e.g., sit, down), the clinician and staff can test these responses. If a nonaggressive dog has a problem with jumping into people’s laps, the technique of discouraging this behavior by repeatedly standing up and turning one’s back to the dog can be demonstrated to the owner. However, some dogs are so intimidated by strangers or nov-
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In cases of extremely fearful or aggressive patients that appear to be physically healthy when observed and not touched, and for which the owners report no physical signs or history of trauma, subjecting the patient to a physical examination on the first visit may cause excessive stress, making the physical examination counterproductive. 

If the history indicates any degree of aggression, or if the initial behavior of the dog when it enters the examination room indicates that it might become aggressive, then the dog should remain restrained on leash by the owners. Diagnosis can be facilitated by observing the dog’s signaling. For example, does it prick its ears toward the clinician or pin them back against its head? Does it hold its tail low or high? Does it show its teeth? If so, how? (Lifting the rostral lips off the incisors and canines may indicate strong self-confidence and dominance, whereas pulling the commissure of the lip caudally to expose the premolars and even the molars usually indicates strong fear.) Does the dog react differently to specific movements or to specific people? Are the dog’s reactions consistent with the history? If so, a stimulus discrimination (e.g., fear of men, fear of people wearing hats) may be confirmed. If the reactions are inconsistent with the history, the dog’s behavior problem may be in response to a more general set of stimuli.

Observing the Pet at Home

The development of inexpensive video cameras has been of great benefit to the practice of veterinary behavior. Many pet owners own a video camera (digital or tape) or can borrow one. While a great deal can be learned from interviewing people who know the patient and observing the patient in the exam room, some behaviors can only be fully understood by observing the pet in its regular environment. In some of these cases, a home visit is adequate. However, home visits are often impractical, and in many cases, the pet may not exhibit the undesired behavior when a stranger is in the house.

Asking the owner to make a video of the pet’s behavior at home is beneficial in many situations, such as cases of conflict between two or more pets, particularly during specific situations that only occur in the home. Videotaping the pets in this context may provide critical information about their relationship, especially when the owners do not have a good understanding of normal, species-specific behavior. For example, two dogs presented to my clinic for fighting. The written descriptions provided by the owner suggested that the dogs were simply engaging in vigorous wrestling play. However, I could not be entirely confident of this diagnosis based only on the owner’s description. Videotaping of a “fighting” incident by the owner confirmed that the dogs were merely engaging in very loud, boisterous play behavior. Videotapes can also verify and clarify descriptions by owners of pet behavior that is extreme or abnormal, such as a cat repeatedly throwing itself violently against a baby gate in an attempt to attack a cat on the other side of the gate.
Physical Examination
Performing a physical examination is, of course, always desirable. However, touching an animal with severe fear of humans can be extremely stressful for the patient. If the owner reports that he or she has not observed any physical signs of illness (e.g., vomiting, diarrhea, coughing, sneezing, runny eyes, lumps) and the patient looks physically healthy, but the patient is likely to have an extreme response to a physical examination, such as violent trembling, struggling, or screaming, the potential to exacerbate the behavior problem by forcefully subjecting the patient to a physical examination should be weighed against the possible benefit of performing the examination. This is also the case with extremely aggressive animals. The stress caused to the patient by subjecting it to the restraints and/or medications that may be necessary to make a physical examination possible and safe for the veterinary staff may outweigh the benefit of the examination. In the extreme cases that are referred to my own clinic, it is not uncommon to delay a physical examination until the second or third visit, when response to the initial treatment makes it possible to examine the patient without causing it excessive stress or placing anyone in undue danger.

QuickNotes
In many cases, it is useful to ask the client to videotape the pet in its home environment.

Conclusion
Assessing a patient with a major behavior problem is not a quick process. Obtaining a written history provided by people familiar with the patient, directly interviewing people familiar with the patient, watching videotapes of the patient, and directly observing and interacting with the patient in the examination room are all valuable tools for gathering information. The more of these tools that can be used in assessing a patient with a behavior problem, the more likely it is that the problem can be accurately diagnosed and a treatment plan that can be effectively implemented by the family can be developed.

TO LEARN MORE
For more information about how to obtain clinically relevant descriptions from owners, see the December 2008 article “Behavior Assessment: History Forms and Interviews” at CompendiumVet.com.