THE
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A Publication of the Montana Psychological Association

President's Perspective

Karen J. Kietzman, PsyD, MPA President

Your board at work.

The MPA board has been discussing many changes within our organization. We have already instituted some changes in our structure and business. A few years ago, for example, we made a decision to reduce our board from 9 members to 7 board members. This was to increase efficiency in voting as well as reduce other costs inherent in having board meetings and other communications.

One of the more recent changes that you may have already noticed is the change of our offerings of CE conferences. We have decided to go from two 2-day conferences to one larger state convention to be held each spring. This decision was driven by an aim to reduce costs and increase revenue. Our first annual convention, which took place last April, was highly successful and profitable. Not only was it well received, but it was well attended, providing plenty of opportunities for networking. Our next convention will be equally interesting and educational. Dr. Marla Lemons, our CE chairperson, and her committee have been hard at work to bring these highly valuable conferences to our membership. I look forward to what they have in store for us.

I am proud to inform you that, because of this change, we have a shift in our revenue base. We are in the black earlier in the year than we normally are. With your support in joining us, that will continue to be a welcome change and we can breathe a sigh of relief! This is a good time to ask you to please get your membership dues for 2019 submitted by years end! We really appreciate it. It affords us a stronger voice to promote our mission as well as remain financially sound.

In other news, the MPA Board of Directors held a retreat in Helena earlier this fall. We discussed a number of issues facing the professional practice of psychology, with some related to pending issues in front of the Board of Psychologists as well as legislative "issues in progress". We will draft and share a full report as soon as we are able to make sense of it all. As an aside, we are always looking for new voices and energy for the MPA Board. If you are interested in joining us, please contact Marti or me directly.

PSYPACT is one issue the MPA Board discussed directly. PSYPACT is an interstate compact that will allow licensed, doctoral-level psychologists to practice telepsychology across state lines without having to get a license in all compact states. As long as psychologists hold a license in a state covered by the compact, they will be allowed to practice remotely without needing a license in any of the other compact states. PSYPACT also allows for 30 days of temporary, in-person practice in a compact state. PSYPACT is governed by legislation, and it will become operational once seven states pass the legislation enacting it. Arizona was the first to begin the process in 2016. Nevada, Utah, Colorado, Nebraska, Missouri and, most recently, Illinois have all followed suit. Illinois' legislation goes into effect in 2020, so for now, PSYPACT is still waiting on that last state before it can begin. As you may be wondering, PSYPACT in Montana may have great potential as well as some pitfalls. One of the possibilities is that it will help us with the pressing need for high quality mental health care for rural residents. As a potential downside, PSYPACT would allow psychologists who have not been vetted by the MT Board of Psychologists to serve Montana clients. It is the BoP's job to keep the public safe. If a psychologist is vetted in a PSYPACT state and not the MT BoP, some psychologists who serve Montanans may not meet Montana licensure standards. If we decide to pursue this option, careful evaluation of the wording of the law will need to be

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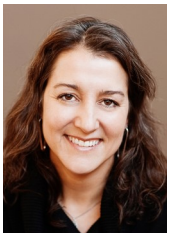
assessed. At present, MPA does not have an official position on PSYPACT. It will be another lively discussion between the members. If MPA ends up supporting PSYPACT, it will take a legislative push to make it happen here. Please feel free to communicate your thoughts about PSYPACT to anyone on your board.

Finally, the most important decision we made in Helena is to establish a *Gyda Swaney Award*. We will be developing criteria through the joint efforts of MPA, the University of Montana Psychology Department, and the Society of Indian Psychologists. If you would like to participate in this discussion, please contact me via email with your thoughts. If we decide to develop a financial award, we would invite all of you to contribute.

Legislative Report December 2019

Michele McKinnie, PsyD , MPA Legislative Chair



Here is a summary of MPA's 2019 Legislative activities and a look ahead into 2020:

The 2019 Session was busier than 2017; this was hard to imagine at the close of 2017 yet it happened. I am concerned that this is a sign of things to come for the upcoming session in 2021. The latter half of 2019 has been quiet for MPA in terms of legislative activities however we have continued to watch for committee and legislative activity that may impact Montana Psychologists and the people we serve. If you ever have questions about what we are noticing please feel free to reach out to me – my email is at the end of this report.
As we look toward 2020 I would like MPA members to be prepared for requests from the Legislative committee to reach out to your state representatives either with regard to specific issues or to make connections that can serve us in the coming session. Grassroots efforts are firmly based in relationships and the success of those efforts relies on good relationships that are build early in the process. Last minute 'hail Mary' requests from previously unknown constituents rarely have as positive an impact as a semi-regular contact from a known mental health resource. If you are unsure how to identify who your legislators are please also let me know – we can help you with that too.

You can get involved!! Participating with the Legislative Committee is an interesting way to be involved in the profession of psychology outside the office and can expand your impact in other ways. Please reach out to me at michelecatherine@hotmail.com should you have any interest in joining us. The MPA Legislative committee wishes you a healthy and peaceful holiday season!!

MEMBERSHIP COMMITTEE INFORMATION

MPA is pleased to let you know Dr. Greg Machek (Missoula), is chairing the Membership Committee. Dr. Michele McKinnie (Bozeman), is currently a member of the committee. They would like to welcome anyone interested in ensuring the vitality and sustainability of MPA as an association, and enhancing the experience of membership within the association, to join! Please contact Greg (gmachek@hotmail.com) or Michele (michelecatherine@hotmail.com) with input and interest – *the more the merrier!*

Important facts related to membership:
MPA dues are based on a calendar year schedule. Regardless of when you paid dues in 2018, you are up for renewal on January 1, 2019. *Don't wait – renew now!*

Your dues give you many benefits, including member prices on continuing education, all 4 quarterly issues of *The Montana Psychologist*, access to ethics and professional consultations, a voice in the legislative process, and much more.

Alarming Facts About Suicide

Donna Zook, PhD

Depression is often associated with attempted and completed suicide. At the November 14, 2019 meeting of the Behavioral Health Advisory Council (BHAC) of which I am a member, Karl Rosston, LCSW Suicide Prevention Coordinator at the Department of Public Health and Human Service (DPHHS) presented alarming statistics on suicides in Montana. Montana ranks in the top five suicide rate in the nation for the past 40-years and near the top for a century. The 2017 National Vital Statistics Report documented that Montana has the highest rate of suicide in the nation, a rate of 29.6 nearly double the national rate. Suicide is the second leading cause of death in Montana for people ages 10 to 44.

The completed suicide rate in Montana for youth ages 11 to 17 is 12.6 for every 100,000 people and nearly 10% of all high school students and nearly 16% of all middle school students have attempted suicide in the past year. For American Indian students living on reservations nearly 19% have attempted suicide one or more times in the past year. Sixty-five percent of youth suicide was by a firearm. LGBTQ youth are three times more likely than straight peers to attempt suicide but four times as likely to complete suicide. Being victimized from peers increases the likelihood 2.5 times. Additionally, one in twelve college students attempted suicide inn Montana. Completed suicide by Montana veterans is 65.7 for 100,000 which is triple the national rate. Elderly Montanans have a 16.7 rate of completed suicide.

Additionally, completed suicide rates of divorce individuals is 59.6, for single or never married is 34.0, for widowed individuals the rate is 29.9, and for married individuals' the rate is 19.0. Completed suicide of individuals with less than high school education is 43.5, a high school graduate or equivalency is 39.5, some college is 28.6, and individuals with a bachelor or higher degree is 20.1. In Montana, the suicide rate using a firearm is 62.2, by hanging or strangulation or suffocation is 20.5, by drug poisoning (not including alcohol) is 9.4, other means such as motor vehicle accidents or jumping off high structures is 5.0, and other poisoning such as carbon monoxide is 2.0.

When comparing age, gender, and race, Montana percent of suicide statistically exceeds that of the national average as evidenced with the following statistics.

	MT	National
Males	37.3	20.72
Females	10.9	5.74
American Indians	28.5	16.3
Age: 0-14	2.1	0.7
15-24	23.8	11.9
25-34	33.7	15.4
35-44	34.9	16.8
45-54	31.7	20.0
55-64	31.1	18.5
≥65	24.0	16.3

The Montana Counties with the highest suicide rates are: Deerlodge (39.6), Rosebud (39.2), Roosevelt (38.4), Stillwater (34.7), Park (33.2), Custer (32.1), Silverbow, and Lincoln (30.5).

According to research the Rocky Mountain States have the highest rate of completed suicide which include Montana (29.6), Wyoming (27.1), Alaska (27.0), New Mexico (23.5), Idaho (22.8), South Dakota (22.0), Utah (21.4), and Colorado (21.1). There are several geographical, social, and biological factors contributing to the higher suicide rates in the Rocky Mountain States. Interestingly altitude is a factor since elevations > 2,500 feet cause oxygen depletion over the long term and when coupled with shorter daylengths approximately six months of the year the result is a Vitamin D deficiency. Vitamin D deficiency lowers the serotonin level which increases depression. People are more isolated in the Rocky Mountain States and Montana has only 6.7 people per square mile whereas the national average is 1588.7 people per square mile. The reduced population, particularly in geographically large states such as Alaska and Montana result in social isolation. Montana also has a higher than average lack of behavioral health services and alcohol abuse is a common coping strategy for depression. Additionally, one in five children in Montana live below the federal poverty level, Montana has 65% more suicide by firearms than the national average and nearly 90% of all deaths by firearms is a suicide.

In my view these are alarming statistics but I also have confidence that we Psychologists are equipped and trained to address the issue of depression, pain and suffering of our citizens and their families. Also, in my view there is no doubt we are called upon to treat one or more individuals with depression with or without admitting to thoughts of or attempts at suicide. We also have been called upon to treat individuals who have been affected by a loved-one who committed suicide. Because of our dedicated continuing education committee, MPA has the opportunity to benefit from recent research on the contributing factors in human pain and suffering that lead to attempted and completed suicide. With continued learning, we are in a better position to prevent suicide and perhaps the rate of suicide will decline to below national levels.

SARC: Trauma-Informed Practice at the University of Montana

Alex Buscaglia, MA

For the last two and a half years, I have been working as a graduate clinical intern at the Student Advocacy Resource Center (SARC) at the University of Montana. The University of Montana received national attention in recent years following the publication of Jon Krakauer's *Missoula: Rape and the Justice System in a College Town* (2015), which detailed the author's perspective on a series of sexual assault cases that occurred on the university campus. Concurrently, over one-hundred universities across the U.S., including the University of Montana, were investigated for their handling of campus sexual assault by the Department of Justice (DOJ), as survivors brought forth Title IX claims at a national level. While college campus sexual assault certainly is not unique to the University of Montana, I have been fortunate to experience how a survivor-driven movement has resulted in systematic change at UM. In my experience, one of the driving forces for change at UM has been the prevention education programs and confidential direct services that SARC offers to students who have been impacted by sexual assault, relationship violence, discrimination and/or harassment. Because of the availability of these services and the impact that this organization has had on the UM culture and community, I truly believe that SARC is a "hidden gem" at the University of Montana. I write to you today to share how my clinical experience at SARC has impacted me as a growing clinician.

A large part of what I do as a SARC student clinician and advocate is to spread awareness of SARC services across UM's campus. I am frequently asked to share information about SARC and the services we offer to faculty, administrators, and students. I think it is important to note that not all universities have a confidential resource on campus that is uniquely tailored to support the needs of survivors; and, my hope is that by doing this work, more college campuses will adopt similar agencies. At UM, SARC provides direct service support to primary and secondary survivors of interpersonal violence and victimization in the form of counseling and advocacy services. Survivors can attend up to 12 free individual counseling sessions, as well as access medical, academic, and legal advocacy services. SARC also manages a 24-hour crisis hotline for those in need of emotional support, resources, and connection to services after standard business hours, and occasionally offers group workshops and support. Outside of direct client services, part of SARC's mission is to help foster an environment on campus in which all students have the opportunity to pursue their academic goals free from discrimination and unwelcome physical, sexual, emotional, and social coercion. SARC pursues this goal by providing trainings and preventive education programs to faculty, staff, and students across campus on topics such as healthy relationships, microaggressions, being a first responder, sexual assault prevention and response, and resiliency. As a part of our mission to change the campus climate around sexual assault, we also provide an evidenced-based prevention education program called "Bystander Intervention" to all incoming students. This program teaches students basic facts about college campus sexual, consent, and factors that contribute to sexual violence. It also helps students recognize the signs of potentially dangerous situations and provides them with some simple strategies for intervening effectively and safely to prevent sexual assault.

As a clinical psychology graduate student, my main area of research and clinical interest is in trauma work; specifically, I interested in understanding and treating sexual assault and relationship violence among college students. Through work at SARC, I have been exposed to many therapeutic approaches, including DBT, CBT, ACT, CPT, and PE interventions and their applications to trauma. My exposure and practice with these therapeutic techniques has allowed me to help my clients therapeutically target feelings of self-blame, guilt, shame, lack of safety, intimacy issues, and self-esteem. At SARC, many of the clients who seek services are in acute crisis, and, therefore, require basic needs like safety and security to be met prior to engaging in "heavy" trauma work. In my development as a trauma clinician and researcher, I have appreciated the opportunity to work with clients at various stages of healing. I have witnessed how the clinical and advocacy needs of someone in acute crisis may be vastly different from someone who has experienced a past trauma. This work has also helped me to further understand different clinical presentations and stages of change in relation to interpersonal violence and sexual assault. Such trauma experience will undoubtedly be immensely beneficial for internship and postdoctoral placements at VA clinics, hospitals, and inpatient psychiatric units.

Unlike other training "practicum" opportunities for graduate students, at SARC, I am afforded a chance to wear several different "hats" due to the "wrap-around" nature of direct services offered. As interns, we play the roles of therapist, advocate, and educator. As a clinical psychology graduate student, my experiences at SARC have been invaluable and uniquely varied in a way that has allowed me to gain not only therapeutic training, but integrated-care experience. My role at SARC often requires that I work as part of a team of community and campus professionals (e.g., with sexual assault nurse examiners (SANE) at First Step in St. Patrick's Hospital, law enforcement officers and detectives, Crime Victim Advocates Office (CVA) in Missoula, the Title IX coordinator at UM, the YWCA of Missoula and other local shelters and resources) in order to provide holistic care to survivors. I often work with individuals in acute crisis, whether I am called into the hospital to provide emotional support and resources to a survivor and their loved ones, or working with a client who has dropped-by the SARC office for an unscheduled visit. I strongly believe that this type of acute crisis work necessitates coordination of care with community and campus providers to ensure that survivors understand their options, feel empowered to make informed decisions, and are supported throughout their healing process. Importantly, we also work with our campus and community partners to provide and receive feedback on services delivered to clients in order to continually improve our functionality as a care network. Coordination with these various agencies and professionals has given me an

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SARC: Trauma-Informed Practice (continued from page 4)

appreciation for viewpoints outside of the mental health field, and has enabled me to become a more knowledgeable and skilled clinician. While I may only meet with each of my therapy clients for approximately an hour per week, they live their lives and navigate these systems daily, often without assistance. I am grateful to SARC for allowing me the opportunity to work as a part of a client-centered team that assists them in understanding and navigating these systems outside of the context of therapy.

Outreach and preventive education is not traditionally thought of as a "meaningful clinical experience;" this is another "hat" that I wear at SARC that I particularly value. I believe that it is incredibly beneficial as a clinician and advocate to be aware of the general climate, knowledge, and attitudes that the UM campus and surrounding community hold toward sexual assault, relationship violence, and mental health. This helps our organization target areas of deficiency in services, develop ways to increase access to care, and plan for future training/educational opportunities on our campus. Through educational presentations, SARC clinical interns are also able to directly connect and engage with students who might not otherwise reach out for support. Through these presentations, I have had the opportunity to increase faculty, staff, and students' awareness of SARC services and contribute to changing the culture around sexual violence at UM.

While the opportunities that SARC offers clinicians-in-training are enriching and powerful, we are also exposed to the harsh reality of funding difficulties and limited resources that so often hinder the progress of agencies like SARC. As a result, the staff and graduate students at SARC carry heavy caseloads, deal with limited space and resources, and have to continuously monitor signs of clinician burnout. In the last academic year alone, SARC saw over 300 new clients (not including returning clients from previous years) while operating with seven part-time clinicians and two therapy rooms. As a drop-in clinic, it is difficult to schedule and find space for all of the recurring and in-crisis clients. Our frustrations are unfortunately not unique, as other non-profit organizations like the local YWCA, which provides similar services to survivors in the community, are also severely underfunded and understaffed. It's simultaneously frustrating and encouraging to think about how many more clients could receive services and safe housing if these agencies were funded appropriately.

While trauma work can be challenging for a multitude of reasons, I think it will be even more difficult for me to leave my SARC family and environment as I continue to further my clinical training during my internship year. I truly believe that I am a better clinician for having worked with the inspiring people who are drawn to SARC, as I was, and with our community partners. Due to my clinical training at SARC, I will carry with me an emphasis on empowerment and trauma-focused therapy at the client's pace in my future clinical work. I will also continue to pursue research focused on improving prevention programs and intervention strategies for survivors. Most importantly, I now feel more comfortable working with clients in various states of crisis and working as part of a client's healthcare team. Moving forward, I hope to continue working with trauma survivors, while utilizing my passion for social justice, which has largely been cultivated through my time at SARC.

From the Office

In the coming months when you log into the website, pay your dues online or register for a conference, you will see a different look. We are upgrading our management systems and website. As with all things that "are improved", we're experiencing some growing pains.

I hope you'll be patient with us and if you have a problem, please let me know. It isn't meant to be frustrating but I know it is and appreciate your help.

Everyone will need to set a password for their membership access, when you receive a message from Wild Apricot – please go through the steps for your new personalized password. For my office, it's like getting a new EHR!

Emotional Support Animals: Emerging Best Practices for Managing Requests - *Leslie Trumble, Psy.D.*

Requests for emotional support animals (ESAs) have been on the rise in the last few years. If you have been following the news, you've probably heard about some over-the-top ESA antics – peacocks at airports, animal-filled dorms, etc. While it is easy to have a "tsk tsk" response to some aspects of this trend, there is compelling research suggesting that some animals can have a positive impact on the emotional wellbeing of their caretakers. Whether or not we are prescribing them, ESAs are a reality in the current mental health scene and in some of our clients' lives.

In my private practice, I get frequent requests for ESA letters, often from current clients who want an animal in a housing situation that would not otherwise allow them. Because this type of assessment is out of my scope of competence, I opt not to write these letters. My aim is usually to have conversations with clients about alternative living situations, other coping skills or support systems, and so on.

In an ideal world, I could respond to each request as I would for a request for a chemical dependency or neuropsychological evaluation by saying, "This isn't my area of practice, but let me refer you to my colleague who knows more. I can provide information about our work together and your mental illness, and they will likely ask you more questions about your mental illness and your need for animal." Unfortunately, I haven't found anyone in the state with this expertise.

Meanwhile, I am concerned that we are inadvertently punting this issue to other practitioners who, with or without expertise, will just write the letter. In the worst cases, the client pays for a "certification" of an ESA based on their answers to an online questionnaire (note that ESAs need no certification or even any special training; these services have recently come under scrutiny of state boards and some are considered to be predatory) (Caldwell, 2019). I've been wondering how we might handle all of this better. This is the first in a series of two articles exploring the issue of emotional support animals. Here I look at general information and published guidelines.

Human-animal interactions. There is a lot of research on interactions between people and animals, much of which suggests that, broadly speaking, interactions with *safe* animals can have a multitude of positive effects on people. Beetz, Uvnäs-Moberg, Julius, and Kotrschal (2012) provide a review of literature, pointing to studies that suggest social behavior, social attention, interpersonal interactions, mood, heart rate, and blood pressure show improvement in certain human-animal interactions. They hypothesize that a common factor in beneficial interactions may be the activation of the oxytocin system. There have been additional intriguing studies of interspecies neurobiology and attachment in the past few years (e.g. Thielke & Udell, 2017).

Research specifically on companion animals (such as ESAs or pets) for people with mental health diagnoses has been spotty – there is good research in the area of dogs used to help veterans manage PTSD symptoms, for example, but this doesn't necessarily generalize across populations, conditions, or animal species. Brooks et al. (2018) as well as Crossman (2016) suggest that more research is needed to better understand the extent to which animal ownership or companionship can be helpful to people with mental illness.

ESAs vs. service animals. Unlike service animals, which are trained to do work or perform tasks on behalf of someone with a disability, ESAs do not have to be trained to perform any specific task. They can, by their presence alone, ameliorate symptoms of a person with a psychiatric disability. If a client wants an animal that is *trained* to remind her to take medication or snuggle up to her when she shows signs of panic, she might actually be looking for a service animal. The Americans with Disabilities Act does not protect ESAs, only service animals, and states that they can only be dogs or miniature horses (United States Department of Justice, 2011). Another difference is that a service animal can accompany an individual with a disability anywhere, whereas ESAs are only protected by law in living situations and on airlines. If a client requests an animal that can accompany them in public spaces, they are looking for a service animal. Notably, fraudulently presenting an animal as a service animal can be a misdemeanor in Montana as of spring of 2019 (MCA 49-4-221 and 49-4-222).

Legal protections. There are two acts, the Air Carrier Access Act (ACAA) and the Fair Housing Act (FHA) under which ESAs have rights. Under the law, ESAs are not restricted to certain species, though some airlines are only allowing certain animals. In the case of the ACAA, emotional support animals with correct documentation can ride in the cabin with their owners at no additional cost (Air Carrier Access Act, 2003). Under the FHA, emotional support animals are considered a reasonable accommodation that landlords (and HOAs and dorms, etc.) must make for tenants who require them due to a disability, without charging additional fees they would charge for a non-prescribed pet (Fair Housing Act, 1986).

Assessing the client. Both the ACAA and FHA require that the person permitted to have an ESA be considered *disabled* by a psychiatric condition. It seems that the definition and determination of disability varies widely in the practice of ESA recommendation. On one end of the spectrum, the Human -Animal Interactions in Counseling Interest Network suggests in a position statement that the animal need only be "necessary for the individual's treatment." On the other end, Younggren, Boness, Bryant, and Koocher (2019) go so far as to suggest a thorough disability assessment akin to those given when one is seeking social security disability insurance, including an evaluation for malingering, preferably done by a practioner experienced in forensic evaluation. The HAIC says only a treating clinician should write such a letter; Younggren, Boisvert, and Boness (2016) suggest

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To: Montana Psychologists

From: Karen Kietzman, Psy.D., President
Montana Psychological Association (MPA)

Re: **Membership in the Montana Psychological Association**

I'm writing to encourage you to renew your membership or to join the Montana Psychological Association for 2020.

"Every [person] owes a part of [his/her/their] time and money to the business or industry in which [he/she/they] is engaged. No [one] has a moral right to withhold... support from an organization that is striving to improve conditions with in [his/her/their] sphere." ***- Theodore Roosevelt.***

Your membership supports the well-being of your profession and is your professional home.

Membership in MPA provides multiple benefits, including:

1. Discounts on in-state continuing education offered by MPA,
2. An opportunity to create your professional community, network, and share information with your colleagues across the state via the MPA listserv and at MPA meetings,
3. Representation of your concerns to the legislature, Board of Psychologists, third party payers, APA, and other national entities that directly impact the practice of psychology and the lives of our clients,
4. Advocating to the Montana Legislature regarding important issues that affect psychology and mental health,
5. Opportunities to serve in the leadership of Montana's only professional psychological association,
6. Receipt of ***The Montana Psychologist,*** MPA's quarterly newsletter,
7. Access to MPA's membership-only website which includes insurance and legislative information
8. That good feeling that comes from joining your colleagues in supporting the protection and advancement of your profession in all its forms!

Join today and help us help you!

RENEW ONLINE: ***www.montanapsychologicalassociation.org***

2020 will be a busy year; We hope we can count on you!

2020 MEMBERSHIP FORM
Montana Psychological Association

Membership applications and renewals may be submitted online at:
www.montanapsychologicalassociation.org

☐ **New** ☐ **Renewal**

Membership type:

_____	Student	$ 25.00
_____	Year 1: Calendar year of original licensure	$ 55.00
_____	Year 2: 2nd calendar year of original licensure	$ 100.00
_____	Year 3: 3rd calendar year of original licensure	$ 140.00
_____	Year 4: 100% Membership dues	$ 225.00
_____	Abatement for members earning <$35,000/year	(-$50.00)
_____	Affiliate (out of state or non-PhD/PsyD Montana resident)	$ 80.00
_____	Special Circumstances	$ 80.00
_____	NEW Academic/Experimental colleague	$ 80.00

_____ **TOTAL TO BE REMITTED WITH FORM TO ADDRESS BELOW**

Name: _____ **Birth Date:** _____

Preferred Mailing Address: _____

Work Phone: _____ **Fax #:** _____ **Home Phone:** _____

Cell Phone: _____ **Email:** _____

Received Degree From: _____ **Year Received:** _____

MT License #: _____ **Other State License #:** _____

APA Member #: _____

APA STATUS: ☐ Member ☐ Life ☐ Fellow ☐ Associate ☐ Student Affiliate

Donations:

_____Charles Kelly Memorial Award _____Gyda Swaney Memorial Award _____ Legislative Fund

☐ **If you wish to receive referrals based on your specialty, please list below:**

_____

_____

Send payment and completed application form to:

Montana Psychological Association
36 So. Last Chance Gulch, Suite A, Helena MT 59601
Phone: 406.443.1160, ext. 3; Fax: 406.443.4614

The tax deductibility of dues paid to MPA as an ordinary and necessary business expense is subject to restrictions imposed as a result of lobbying activities. MPA estimates that the nondeductible portion of your dues is 28%.

CE Test December 2019

Earn 1 CE credit by reading this newsletter and correctly answering 80% of the following 5 questions. To obtain your CE credit: mail, email, or fax a copy of your completed quiz to MPA. If you are not a current MPA member, please mail the quiz in with your check for $25.00. Newsletter CE credits are provided free of charge only to current MPA members. Credits may be applied for up to three months following the newsletter's publication.

1. Which among the following is the estimate of the prevalence of transgender identity in Montana?

   a. .05%
   b. 5%
   c. 10%
   d. .1%
   e. .3%

2. Which among the following is true?

   a. All local governments in Montana have Non-Discrimination Ordinances (NDOs) that protect transgender persons against discriminatory practices in housing, employment and public accommodations.
   b. In Montana no state level protections exist to shield LGBT people from discriminatory practices in housing, employment and public accommodations.
   c. Rural communities in Montana are more likely than urban communities to have NDOs that protect transgender persons from discriminatory practices.
   d. Transgender persons who live in Montana communities that have NDOs that protect. transgender persons from discriminatory practices report higher anxiety related to gender identity than transgender persons from communities without NDOs.

3. Research conducted by a team of scientists at the University of Montana and Montana State University concluded which of the following?

   a. There appears to be no relationship between distress and one's ability to live as his/her/their 'true self', or consistently with one's gender identity.
   b. Distress decreases as one is better able to live as his/her/their 'true self', or consistently with one's gender identity.
   c. Distress increases as one is better able to live as his/her/their 'true self', or consistently with one's gender identity.
   d. Fewer than 1/2 of transgender persons in Montana experience suicidality, and less than 1/3 reported past suicide attempts.

4. According to the recent MPA psychologist survey, which activity was rated by the highest proportion of respondents as something that MPA does well?

   a. providing continuing education
   b. serving as a professional home
   c. providing information via the listserv
   d. advocating for the profession
   e. networking

5. According to the recent MPA psychologist survey, which among the following is/are things MPA can do to improve respondents' professional lives?

   a. provide assistance with navigating the reimbursement landscape
   b. serve as a clearinghouse or repository of emerging research updates
   c. provide an venue for facilitation of consultation regarding ethical issues and specific clinical issues
   d. improve the 'branding' of the profession of psychology
   e. all of the above

Return completed test to:

Montana Psychological Association
36 S. Last Chance Gulch, Ste. A, Helena, MT 59601
p. 406.443.1160; ext. 3 f. 406.443.4614
e. mwangen@rmsmanagement.com

that a treating therapist making such a determination constitutes a conflict of interest, and an objective third party should perform the evaluation using information from the treating clinician as collateral information. Phillip Tedeschi, who directs the Instituted for Human-Animal Connection at the University of Denver, points out that assessment of the client's understanding of the burdens involved in caring for an animal is crucial, as well as some assurance that the animal will receive adequate care (personal communication, November 5, 2019). The client should also know that if they are deemed disabled, they may face unintended consequences in terms of future employment, security clearance, etc.

Assessing the animal. Guidelines from Younggren et al. (2019) and the Human-Animal Interactions in Counseling Interest Network of the American Counseling Association (2019) emphasize the importance of assessing the animal and outline potential risks if the animal is not appropriate. While ESAs do not require any specific training, poorly behaved or unsafe animals may not be granted permission to accompany their people at home or on airlines. It is important to understand how the animal behaves under a variety of situations. An animal that is distressed among crowds may cause its owner more stress than it alleviates in an airport situation, for example. Working with animal behaviorists, animal trainers, and veterinary staff may be beneficial in determining fitness of the animal.

Assessing the client-animal interaction. It is important that the animal somehow improve the functioning of the client in a way that relates to the disability. Most of us who are animal owners would probably say our pets improve our lives and our connections to them can be emotional and strong. To qualify as an ESA, though, an animal should provide a benefit such as reduction in symptom intensity in the presence of the animal vs. alone, or a significant change in the person's ability to function when the animal is present.

In the next newsletter I plan to discuss how these guidelines are being put into practice and issues being raised by the public around emotional support animals.

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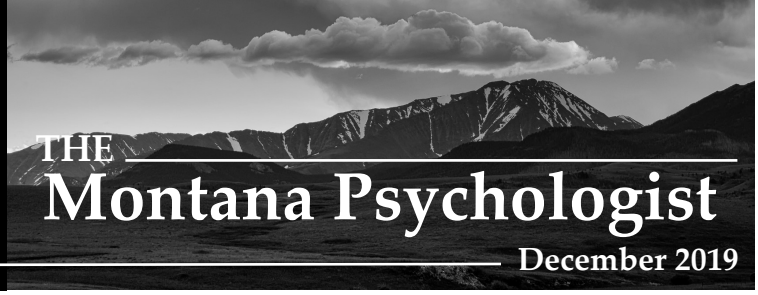

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