

The Certification of Emotional Support Animals:  
Differences between Clinical and Forensic Mental Health Practitioners  
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## Abstract

There is a growing trend of individuals requesting emotional support animal (ESA) “letters” from licensed mental health professionals. However, no current standards exist for making these evaluations. The current study sought to explore (1) roughly how many and what type of mental health professionals are making ESA evaluations and (2) what instruments practitioners use, or would use, for making such an evaluation. Using a sample of 87 mental health professionals, 31.4% of whom have actually made ESA recommendations, the current study demonstrates that both clinical and forensic practitioners within the current sample are making ESA recommendations and both believe it is appropriate for treating mental health professional to offer an opinion on the need for an ESA. This demonstrates that neither group recognizes the potential role conflicts this presents when one mixes forensic and clinical functions. Further, results of the survey revealed that forensic practitioners were significantly more likely to choose more complex and forensically-valid assessment instruments (e.g., malingering assessment) for ESA evaluations when compared to clinical practitioners. We conclude with a set of recommendations for practitioners to choose to conduct ESA evaluations.

### The Certification of Emotional Support Animals:

#### Differences between Clinical and Forensic Mental Health Practitioners

On January 10, 2016, consistent with the requirements of the Air Carrier Access Act (ACAA, 14 CFR 382, 2003), Delta Airlines allowed a passenger to bring a pet turkey onboard one of their domestic flights. This turkey traveled to the destination for free and was given a select seat in what Delta calls the “Comfort Plus” section of the airplane, where it sat next to its owner for the duration of the flight. The bird was allowed onboard, much to the chagrin of other passengers, because the owner provided proper documentation to Delta Airlines claiming the fowl was an emotional support animal (ESA) under the law. Consequently, Delta had no choice but to allow the bird on the aircraft. Having been presented with documentation certifying that the bird was the passenger’s ESA, Delta could have faced legal sanctions if it had failed to comply with the request to have the bird travel with its owner (Cutler, 2016).

Under the law, the ACAA requires airlines to permit ESAs to accompany their owners in the main cabin of an aircraft if the passenger provides current documentation on the letterhead of a licensed mental health professional specifying the passenger is under his or her treatment, has a mental or emotional disability recognized in the Diagnostic and Statistical Manual of Mental Disorders (DSM; APA, 2013), and is in need of the ESA as an accommodation for air travel and/or activity at the passenger’s destination. Additionally, air carriers “shall not impose charges for providing facilities, equipment, or services that are required by this part [of the Act] to be provided to qualified individuals with a disability” (Federal Register Reg. Vol.68, No. 90, p. 24875). This means, in other words, that the animal travels for free. According to the Department of Transportation (DOT), passengers with a mental health *disability* (emphasis added) can travel with their animal in the main cabin of an airplane if that animal is an

“emotional support animal (ESA)” (DOT; 14 CFR Part 382, 2003). However, this requirement fails to address a number of issues including: (1) how one determines the existence of such a disability, (2) how such assessments are conducted in order to avoid exploitation of the regulations, and (3) whether these determinations are, in fact, a special type of professional activity separate from treatment and, therefore, should be conducted separately from treatment.

It must be noted that ESAs are legally different than Service Animals (SA), which have been specifically trained to perform a task for a person with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability. “Psychiatric Service and Emotional Support Animals” published by Disability Rights California (2014), provides an in-depth discussion of the differences between ESAs and SAs. A psychiatric service dog, for example, assists individuals to detect the onset of psychiatric episodes and lessen their effects. These include but are not limited to reminding their owner to take medicine, turning on lights for owners with post-traumatic stress disorder, interrupting self-mutilative behaviors, or keeping disoriented persons out of danger. An ESA is not a SA but rather, provides companionship, relieves loneliness, and sometimes helps with anxiety, depression, or certain phobias. They do not have special training to perform specific tasks to help people with disabilities (Brennan, 2014), and as such, are not automatically allowed for public access in the same way a SA is allowed (Disability Rights California, 2014).

ESA’s are also allowed into “no pet housing.” Although ESAs do not qualify as service animals under the ADA, under the Fair Housing Act (FHA), there are specific obligations required of housing providers which prohibit discrimination against disabled individuals as it relates to housing accommodations (FHA, 1968). A disability is defined under the ADA as a physical or mental impairment which significantly limits a person’s major life activities (U.S.

Department of Justice, 2009). Consequently, if an individual presents with a disability that requires, or the symptoms of which are ameliorated by, the presence of an ESA, under the FHA, the landlord must comply with this request and allow the animal into the facility without the requirement of any related pet fees. Again, the regulation does not address how a disability is assessed, though it is clear that it is the disability determination that drives the claim that the person does have such a disability and that the presence of the animal helps ameliorate the problems that the person experiences as a result of that disability.

Disability determinations are, in fact, quite complex. Disability Determination Services (DDS) requires medical and or psychological evidence (i.e., relevant signs symptoms, and laboratory or psychological test findings) to support the presence of a medically determinable mental impairment (SSA, 2012). Severity of the mental impairment is evaluated on the basis of functional limitations on the individual's ability to engage in work related activities. The Social Security Administration (SSA) indicates that the results of standardized tests can serve as objective medical evidence for a disability determination (Committee on Psychological Testing, 2015). Standardized tests and measures are those which are structured and objectively scored, often based on normative data. In comparison, those measures considered unstandardized (e.g. unstructured interview) call for open-ended responses. These measures rely on clinical judgment and interpretation in arriving at conclusions, a task at which clinicians perform poorly (Grove et al., 2000; Meehl, 1954). Consistent with the SSA, the American Academy of Psychiatry and Law (AAPL) Practice Guidelines for the Forensic Evaluation of Psychiatric Disability (Gold et al., 2008) and American Psychological Association (APA) Specialty Guidelines for Forensic Psychology (2013) point out the importance of requiring objective evidence of psychiatric and

psychological disorders and impairment through the use of standard, systematic examination methods, for example.

Another problem area that exists when a treating psychologist writes such a disability letter has to do with the responsibility of the evaluator to assess malingering. Malingering can be defined as “the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives” (American Psychiatric Association, 2013, p. 726; Bush et al., 2005; Heilbronner et al., 2009). Rogers (2008) provides an extensive review of various response styles, such as malingering in both the clinical and forensic context. According to the Committee on Psychological Testing (2015) and the American Academy of Psychiatry and Law (AAPL) Practice Guidelines for the Forensic Evaluation of Psychiatric Disability, assessing for malingering is essential to making a disability determination, especially if a disability claim is based primarily on self-report (Gold et al., 2008). In a 2002 study, Mittenberg and colleagues examined the base rates of malingering across types of impairment, the context, and the referral source. Notably, the authors found evidence for probable malingering in over 30% of disability or worker’s compensation cases. Other studies have found similar base rates of malingering in these cases (see Committee on Psychological Testing, 2015, Table 2-2). For comparison’s sake, Mittenberg et al. (2002) also present base rate data for probable malingering across different types of diagnoses (adjusting for variance due to referral source) including mild head injury (41%), depressive disorders (16%), anxiety disorders (14%), dissociative disorders (11%) and pain or somatoform disorders (34%). These data clearly draw into question whether disability determinations made without the assessment of malingering are consistent with professional standards of practice.

In a previous paper, Younggren, Boisvert and Boness (2016) reviewed the legal and ethical complexities that accompany providing certification of need for an ESA. In this publication, the authors reviewed the sparse scientific literature that supports the need for these animals. In addition, they discussed how, under the law, these determinations are official disability determinations. The authors emphasized how the landscape of clinical practice was fraught with risk if a treating therapist provided such certification without knowledge that such opinions should be derived from a comprehensive disability determination. More generally, the authors drive home the point that any assessment or evaluation intended to provide information about the client for purposes other than treatment (e.g., disability, testamentary capacity, bariatric surgery) is the role of a forensic psychologist, not the treating psychologist, per professional guidelines (Younggren et al., 2016; Greenberg & Shuman, 1997). As a result, Younggren and colleagues conclude that letters of need for an ESA written by treating therapists are inadequate given the requirements of the law. Further, the provision of such a determination by the treating therapist could constitute a boundary violation. It was the authors' opinion that these types of determinations are arguably forensic in nature and should not be conducted by treating clinicians. That said, there is no extant data that provides a sense of what is actually happening in the profession regarding (1) the provision of these types of certifications, (2) how these assessments are actually being conducted, (3) who is conducting them, and (4) whether members of the profession agree with the position of these authors regarding the existence of a conflict of interest when treating professional provide these types of certifications.

The purpose of this study was to address the above gaps in knowledge by conducting a survey of clinical and forensic mental health practitioners to assess whether they conducted evaluation and certification for ESA, and how, in their opinion, these evaluations should be

conducted (regardless of whether they have actually conducted an ESA evaluation). We predicted that (1) forensic practitioners would choose to use more complex and forensically-valid assessment techniques and instruments, when compared to clinical practitioners, if they were asked to make an ESA evaluation, and (2) clinical practitioners would have conducted more ESA evaluations than forensic practitioners.

## Methods

### Participants

Participants in the study were 112 mental health practitioners. Participants were recruited from May, 2016 to July, 2016 via a series of psychologist-based listserv e-mails that explained the purpose of the survey and invited them to participate. The recruitment email emphasized that participation was completely anonymous. The listservs included were the American Psychological Association's Division 41 (i.e., American Psychology-Law Society) and Division 42 (i.e., Psychologists in Independent Practice). To be eligible for participation, subjects had to be over the age of 18 and self-identify as a mental health professional. One participant (0.9%) was excluded because they did not consent to participate. Twenty-four (21.4%) additional participants started but did not complete the entire survey and were therefore excluded from the analyses. The final sample comprised 87 mental health practitioners (see Table 1 for participant demographics). Participants were asked to indicate whether they worked in a forensic practice ( $n = 25$ ; 28.7%), clinical practice ( $n = 37$ ; 42.5%), or combined ( $n = 25$ ; 28.7%). Given practitioners who function as combined forensic and clinical practitioners have similar training to forensic only practitioners, specifically with regards to disability assessments, these two groups were combined in a group referred to as "forensic" from here forward. The final groups used for the analyses were forensic ( $n = 50$ ; 57.5%) and clinical ( $n = 37$ ; 42.5%). The forensic and

clinical groups were similar in terms of their age, highest level of education, years practicing, licensure status, and whether or not they had a law degree. However, Chi-Square tests demonstrated that the two groups differed significantly in terms of sex and American Board of Professional Psychology (ABPP) certification (see Table 1).

### **Measures and Procedure**

The following measures and procedures were approved by The University of Missouri Human Subjects Institutional Review Board. Participants who met requirements for participation in the study could access the anonymous online survey via the link provided in the recruitment e-mail. They were required to complete an electronic approved informed consent form before beginning the questionnaire.

Participants were asked a series of questions about their demographic characteristics (i.e., sex and age) and professional practice information. Participants indicated the type of practice in which they currently work, how many years they have been practicing, and whether they are a licensed mental health practitioner as well as what type of licensure they currently possess. Participants then indicated their highest level of education completed, if they had a law degree, whether they had an American Board of Professional Psychology (ABPP) certification and, if so, what type.

All participants were then asked to read the following description carefully:

According to the Department of Transportation (DOT), passengers with a mental health disability can travel with their animal in the main cabin of an airplane if that animal is an “emotional support animal (ESA)” (DOT; 14 CFR Part 382, 2003). Passengers who have such a disability may have to provide the airline with current documentation on the

letterhead of a licensed mental health professional stating: (1) that the passenger has a mental health-related disability listed in the DSM-IV; (2) that having the animal accompany the passenger is necessary to the passenger's mental health or treatment or to assist the passenger; (3) that the individual providing the assessment of the passenger is a licensed mental health professional and the passenger is under her/his professional care; and (4) the date and type of the professional's license and the state or jurisdiction in which it was issued (Federal Register Reg. Vol. 68, No. 90).

Participants were then instructed to indicate which tools or techniques they would use to arrive at a conclusion or recommendation for a client's, patient's and/or individual's need for an ESA. Responses were in a dichotomous yes/no format, however participants were also given the option "I choose not to answer this question" which was subsequently coded as missing. Table 2 shows the different response options. Participants could also indicate "other" and enter a text response.

Following completion of the above items, participants were instructed to provide a brief written description of why, or why not, they chose the instrument(s) previously described. This type of qualitative methodology is ideal for investigating perspectives about phenomena that are less understood or less empirically substantiated, as is the case with the current topic (Auerbach & Silverstein, 2003). Finally, participants were asked a series of questions about whether they have made an ESA recommendation, whether they believe it is appropriate for treating mental health professionals to offer opinions on the need for an ESA, and whether they feel qualified to make an ESA determination.

### **Analyses**

To test whether the groups were similar in terms of their demographic characteristics, we conducted a series of chi-square tests of association (See Table 1). To test our hypothesis that

forensic mental health practitioners, when asked to make an ESA recommendation, would choose more complex and forensically-valid measures compared to clinical mental health practitioners, we conducted a series of logistic regressions across the two groups (i.e., forensic versus clinical) to determine if there were any significant differences in the tools or techniques deemed appropriate for use in making an ESA recommendation (See Table 2). Similar analyses were conducted to test the hypothesis that clinical practitioners would be more likely to have conducted an evaluation themselves or make an ESA recommendation when compared to forensic practitioners (See Table 3).

### **Results**

Table 2 shows the reported endorsement rates associated with each of the practice types and the logistic regressions for each instrument/technique. The symptom checklist, Personality Assessment Inventory (PAI) or Minnesota Multiphasic Personality Inventory (MMPI), Brief Symptom Inventory (BSI), assessment of exaggeration or feigning of psychological or cognitive symptoms (e.g., malingering), and “Other” (this option will be described in detail later) were significantly different across the two groups. For these given instruments/techniques, clinical practitioners were significantly more likely to use a symptom checklist or the BSI when compared to those who function as forensic practitioners. Forensic practitioners were more likely to use the PAI/MMPI when compared to those who are solely clinical practitioners. Further, forensic practitioners were significantly more likely to include a malingering assessment tool when compared to their clinical counterparts. Thus, forensic practitioners in the current sample were more likely to choose the more complex and forensically-valid measures offered (e.g., PAI/MMPI or a malingering assessment tool) for making a recommendation about the need for

an ESA as compared to their clinical counterparts. The two groups did not significantly differ in their choice of the other four instruments/techniques.

Those who endorsed the “other” option gave a range of responses indicating various additional techniques or instruments they would use if asked to make an ESA certification. Included in these other responses, for example, were measures of neuropsychological functioning, personality, and traditional trauma measures. The types of suggestions were broad and there were no cases in which more than two people within the same types of practice suggested the same technique or instrument. Nevertheless, the forensic practitioners were significantly more likely to choose the “other” option than the clinical practitioners.

Regarding our second hypothesis about ESA recommendations, Table 3 shows the groups differed significantly in whether or not they have made an ESA recommendation. Significantly more clinical practitioners report having made ESA recommendations compared to forensic practitioners. Interestingly, there were no significant differences across the groups in terms of whether or not they thought it was appropriate to offer an opinion on the need for an individual to have an ESA and whether or not they felt qualified to make an ESA recommendation. Nearly one third (31.4%) of the sample made an ESA recommendation for one or more individuals. This is concerning given 35.7% of participants reported they do not feel qualified to make an ESA recommendation. This finding was examined further to determine if any individuals who said they do not feel qualified to make an ESA recommendation still reported having made a recommendation. Results demonstrated that 2.3% ( $n = 2$ ) of those who do not feel qualified to make an ESA recommendation have, in fact, made one or more of these recommendations. These two participants included one forensic mental health practitioner and one clinical mental health practitioner.

### **Discussion**

The results of this study elucidate a rather shocking state of affairs. The data clearly indicate that despite the existing boundary concerns (i.e., conflicts of interest and role conflicts), detailed by Younggren and colleagues (2016), more clinical practitioners are providing ESA recommendations when compared to forensic practitioners. While this makes sense from the perspective of a client asking a therapist, with whom they have an existing relationship for the assessment, it does not reflect an awareness on the part of the clinical practitioner of the various boundary problems that arise when these types of requests occur. Further, results from the present study suggest that forensic practitioners, when compared to clinical practitioners, tended to choose more complex and forensically-valid instruments and techniques when asked what they would use to make an ESA determination. Although these differences were not always significant, possibly due to the limited sample size, there were, nonetheless, important differences.

Forensic practitioners are not without responsibility in committing these types of errors either. In spite of the potential role conflicts, the majority of forensic practitioners (65.3%) endorsed believing that it was appropriate for a treating mental health professional to make an ESA recommendation. One possible explanation for this is that the ESA evaluation may be quite uncommon for the forensic practitioner because they do not get these types of referrals or, more likely, the cost of doing the evaluation the right way is too high for those parties wanting an ESA evaluation. Consequently, they do not seek out these type of evaluators to provide this service. A second possible explanation is the fact that the wording of certain regulations, such as those from the ACAA, require a letter of support for an ESA from a treating mental health professional without pointing out the potential conflicts in this statement. What is clear, however, is that a

forensic evaluator does not have the boundary problems and potential ethical conflicts faced by their clinical counterpart when they choose to perform these functions. The current study did not allow us to evaluate whether forensic psychologists who made ESA evaluations are doing so for their current psychotherapy clients, particularly if they are operating in a combined clinical/forensic practice. This may be important to examine in future work. Regardless, the current results demonstrate that there is a need to clarify who should be making these evaluations and how.

The results of this study suggest that neither clinical, nor forensic practitioners are familiar with the law and both fail to recognize that the ESA letter is a formal disability determination that puts the treating mental health professional in a situation where therapeutic and forensic roles may be in conflict (American Psychological Association, 2013, 4.02.01). Federal laws recognize ESAs as reasonable accommodations for people with *disabilities* (Tran-Lien, 2013). Therefore, ESA recommendations are more than just a psychological opinion. Recommendations are formal disability determinations under the law and they imply that the individual is disabled by their psychological condition and therefore requires the presence of the ESA to remain psychologically stable (Younggren, Boisvert, & Boness, 2016). The fact that half of the clinicians in the sample have made one or more ESA recommendation again demonstrates that they do not understand that this is a formal disability determination that arguably should be handled by a forensic practitioner who is familiar with the procedures of a disability determination.

Further, the fact that 64.3% of the sample reported they feel qualified to make an ESA recommendation (see Table 3) is alarming given the lack of clear standards for making such an evaluation. To what standards are practitioners comparing their current competencies to make

this type of assessment when none currently exist? As described in the recommendations section, the field would greatly benefit from evidence-based guidelines for making ESA evaluations that are consistent with standards of practice, clinical and forensic literature, empirical literature, and professional ethics.

The current study also demonstrates that the preponderance of forensic practitioners recognizes the importance of including a malingering assessment in their ESA assessment battery, whereas the clinical practitioners do so at a much lower rate. This is problematic given the fact that the majority of practitioners who have made one or more recommendations are clinical practitioners, who are less likely to use malingering instruments. This suggests that a portion of ESA recommendations may be based on false or exaggerated symptoms, particularly if the disability claim is solely based on self-report. This is even further complicated by the fact that, given the nature of these evaluations, there may be clear incentive for an individual to exaggerate their impairment as an ESA certification means their pets can fly free and pet deposits can be waived. It is important for practitioners to understand that the conclusion of malingering in a disability claim case could conceivably constitute an assertion of fraud by a claimant. That is, it is against the law to seek compensation from the government for problems that are purportedly disabling when they in fact are not (Chafetz, Abrahams, & Kohlmaier, 2007; Hunt, 2017). Those practitioners who fail to assess for malingering may be placing themselves at risk of aiding a potentially fraudulent disability claim. Given clinical practitioners in this sample were less likely to state they would include a malingering assessment in an ESA evaluation, they may be at elevated risk for aiding a false claim, even if unknowingly. If questions were to arise about the disability determination, they are likely to be held to the standards of a forensic specialist (Gold et al., 2008).

That being said, malingering is not a dichotomy. Individuals may exaggerate or minimize various psychological symptoms to various degrees for a variety of reasons. A positive result on a so-called malingering test may not denote malingering but rather, the individual might be exaggerating symptoms or deficits on a subconscious level, perhaps as a cry for help. In the case of an individual being assessed by a treatment provider, a positive result on the test may mean the person is exaggerating not for the purposes of being able to use an ESA on a plane, but for the clinician to know how badly he or she feels for therapy purposes no matter how unrealistic the responses may be. In addition, someone might still exaggerate symptoms or deficits, but still meet criteria for needing an ESA. Therefore, evaluation of malingering is imperative to making ESA evaluations.

Some practitioners in the sample, across each of the groups, indicated in their explanations that they would want to evaluate the individual requesting the ESA recommendation in the presence of their animal. For example:

“Since the issue involves a human-animal relationship, I don't believe the human can be evaluated in isolation. Accordingly, my preference would be to observe the animal interacting with the person (analogous to observing parent-child interactions in a custody evaluation).”

“I then want to observe the patient both with and without the animal present, so I can observe the difference in the way the person responds to stressful conditions as they may arise in the [appointment] and also to ensure that the animal actually responds in a helpful way.”

These are valuable observations. However, most mental health professionals are not trained to evaluate animals alone or in the presence of their owner nor do standards for conducting this type

of evaluation exist in the literature. This indicates the need for an outside evaluation of the animal and the relationship between the owner and animal. For example, should basic obedience training be required? Is the animal overly aggressive with others? These are questions that must be addressed in developing standards for ESA evaluations.

Relatedly, practitioners providing ESA letters should carefully consider the broader and potential long-term implications of such a disability determination for the client. A disability determination like this means that the client now has a history of psychiatric disability which may have consequences for future employment, educational opportunities, obtaining security clearances, and impacting other important areas of life. Further, such a classification may also come along with stigma (e.g., Corrigan & Watson, 2002). It is important for professionals to consider how a seemingly simple, though very official, letter is in fact a formal psychiatric disability determination that could have important implications for the client's life. Consequently, the ESA letters should not be provided casually nor should they be written without discussing the potential future consequences this type of letter might have.

According to research published by the National Institute of Mental Health, an estimated 18.1% of Americans age 18 and older, suffered from a diagnosable mental disorder in 2014 (National Institute of Mental Health, 2014) with an average of 26.2% in any given year (Kessler, Chiu, & Walters, 2005). This begs the question as to whether an individual has a mental health-related disability listed in the DSM-5, and whether the animal in question alleviates the person's mental health symptoms in some way if accompanying the person while flying. One can argue that one in four adults could realistically qualify for an ESA. As illogical as it may seem, this would imply the ACAA would allow up to one-fifth to one-quarter of passengers to potentially bring their pets on board the plane if needed.

In addition, the ACAA requires the individual providing the assessment of the need for an ESA not only be a licensed mental health professional, but that the passenger is under his or her care. The ACAA appears to have been unaware of the conflicts that arise when a treating practitioner offers such a certification when they drafted these regulations. The problem lies not only with the treatment provider who engages in a dual role by providing a forensic evaluation as well as psychotherapy, oftentimes not using objective assessment procedures and not adequately assessing for exaggeration of symptoms, but of the Air Carrier Access Act itself.

Overall, these results demonstrate that the role of forensic versus clinical practitioners in ESA evaluations are not well understood by the practitioners themselves or by the organizations setting standards for ESA evaluations. We hope that the current paper, along with Younggren and colleagues (2016), will offer a starting place for addressing these apparent legal conflicts and that future regulations will be revised to more carefully word the requirements in a way that is consistent with mental health ethics and practice standards. Advocacy to improve the rigor of regulations and enforcement are needed. The results of the current paper offer a first look into a lack of awareness regarding these issues both among practitioners themselves and at a more a systemic level.

### **Limitations**

These conclusions should be considered in light of some of the study's limitations. First, the overall sample size was fairly small which may limit the study's power and generalizability. Second, the sample consisted of participants recruited from two listservs which limits the types of mental health professionals sampled. It is difficult to know whether the sample is representative of members of the listservs, divisions themselves, or the field of psychology.

Further work should focus on increasing sample size and including a more diverse sample of practitioners.

Participants were only asked to respond to a hypothetical vignette regarding their decision making related to ESA evaluations. It is difficult to know from the results of the current study what psychologists would actually do in a real-life scenario. As such, the current results are speculation about what psychologists would do faced with a similar situation and does not address which instruments mental health professions are actually using to conduct ESA evaluations. However, recent work on the use of vignette methodologies for studying clinician decision-making demonstrates this can be a useful methodology (Evans et al., 2015) and we believe that, although speculative in nature, it still possesses validity. The current study may have been strengthened by a more rigorous testing of the vignette, as recommended by Evans and colleagues. Despite these limitations, the current study provides a useful first look at the roles of clinical and forensic psychologists in ESA evaluations. Future work should focus on sampling mental health practitioners who have made ESA evaluations in order to evaluate which instruments and techniques are actually being used in practice to conduct ESA evaluations.

### **Recommendations**

In light of these results, we recommend the following guidelines for practitioners who choose to make ESA evaluations:

1. Clinicians who are being asked to provide such a letter need to ask themselves what this letter has to do with therapy. If the ESA letter is a key part of a treatment program, then it is appropriate. However, “key” means that the presence of the animal is not some static state of affairs without a goal, but that this will lead to improvement in the client’s psychological condition. If this is the case, it is our recommendation that therapist make

reducing the need for the animal one of the long-term goals of therapy. If that is not the case, the client should be referred to another, non-treating mental health professional for the evaluation.

2. Requests for ESA letters should be met with the same thoroughness that is found in any disability evaluation. The person requesting the letter should be subject to a comprehensive evaluation to include a look at malingering and how the incentives in these types of determinations may lead to exaggeration of symptomatology. Those unfamiliar with this type of professional service should not take on the task, this includes those who do brief online assessments and provide certification services, which are anything but thorough.
3. Guidelines that outline how these types of assessments are conducted, and who should be conducting them, are needed. These guidelines should be consistent with the standards of practice, the clinical, empirical and forensic literature, and professional ethics. For example, one guideline might address the importance of mental health professionals, and specifically forensic psychologists, including an evaluation of the animal's interaction with the subject of the evaluation. Such guidelines should be made widely available and should be incorporated into current graduate-level and continuing-education courses, seminars, and workshops.
4. Beyond guidelines, mental health professionals need to develop an evidence-based protocol for conducting these types of evaluations that separates, as much as possible, those who are exploiting the system from those who have real emotional needs for the presence of their animal. This is especially true given the current state of the literature

which demonstrates conflicting evidence regarding whether the presence of the animal does anything at all for an extant psychological condition.

5. Consistent with current forensic standards, treating mental health professionals need to incorporate limitations on completing these types of requests at the outset of therapy.

Such limitations should be clearly expressed in the informed consent forms completed by the client. A suggested model for such wording would be:

*Dr. X limits the services provided to you to those that are clinical in nature. Any requests for additional administrative services like disability certification and special accommodations related to a psychological condition may need to be provided by another psychologist.*

*Short-term disability certification by Dr. X will be limited to a period of time not to exceed 4 weeks at which time those determinations will also have to be made by another psychologist.*

*The reason for this policy is to avoid having the performance of administrative functions interfere with your therapy.*

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Table 1

*Demographic Characteristics of Sample by Type of Practice and Associated Chi-Square Test*

Characteristic	Total (% endorsed; N = 87)	Forensic (% endorsed; n = 50)	Clinical (% endorsed; n = 37)	Chi- Square
	%	%	%	
<b>Sex<sup>†</sup></b>				10.4*
Male	38.4	53.0	18.9	
Female	61.6	46.9	81.0	
<b>Age</b>				5.2
25-44	27.6	30.0	24.3	
45-64	55.2	46.0	67.6	
65+	17.2	24.0	8.1	
<b>Education</b>				7.8
PhD/PsyD	93.1	98.0	86.5	
MA/MS	4.6	0.0	10.8	
LCSW	1.2	0.0	2.7	
Other	1.2	2.0	0.0	
<b>Years Practicing</b>				5.7
<5 years	4.6	2.0	8.1	
5-10 years	23.0	26.0	18.9	
11-20 years	20.7	14.0	29.7	
21-30 years	24.1	28.0	18.9	
31+ years	27.6	30.0	24.3	
<b>Licensed Professional</b>	97.7	100.0	94.6	2.7
Psychologist	92.9	93.9	91.4	4.3
Social Worker	2.4	2.0	2.9	
Marriage and Family Therapist	2.4	0.0	5.7	
Other	2.4	4.1	0.0	
<b>Law Degree</b>	8.1	12.0	2.7	2.5
<b>ABPP</b>	26.4	44.0	2.7	18.6*

*Note.* \* $p < .01$ . <sup>†</sup> One participant refused to answer the question regarding their sex.  
 ABPP = American Board of Professional Psychology.

Table 2

*Logistic Regression Comparisons for ESA Recommendation Instruments/Techniques across Types of Practice*

<b>Instrument</b>	<b>Forensic (% endorsed; n = 50)</b>	<b>Clinical (% endorsed; n = 37)</b>	<b>Total (% endorsed; N = 87)</b>	<b>Odds ratio for Forensic versus Clinical</b>
Symptom Checklist	30.6	82.9	52.4	11.0**
Brief Symptom Inventory	22.9	45.7	32.5	2.8*
Malingering Assessment	70.8	40.0	57.8	0.3**
PAI or MMPI	83.3	44.4	66.7	0.2**
Structured Comprehensive Interview	61.2	60.0	60.7	1.0
Unstructured Comprehensive Interview	63.3	74.3	67.9	1.7
Rorschach or other projective	8.3	0.0	4.8	0.0
WAIS-IV or other intelligence test	16.7	8.6	13.3	0.5
Other	47.4	16.7	35.5	0.2*

*Note.* \* $p < .05$  \*\* $p < .01$ . PAI = Personality Assessment Inventory, MMPI = Minnesota Multiphasic Personality Inventory, WAIS-IV = Wechsler Adult Intelligence Scale—Fourth Edition. Other includes a range of other instruments (e.g., Hamilton Anxiety Scale, Post-Traumatic Stress Disorder Checklist). There are some cases in which there are missing values, in this case the cell values are based on the valid responses and excludes those missing. The clinical group was the reference group for the odds ratio analyses.

Table 3

*Logistic Regression Comparisons for ESA Recommendations across Types of Practice*

	<b>Forensic, n = 50 n (%)</b>	<b>Clinical, n = 37 n (%)</b>	<b>Total; N = 87 n (%)</b>	<b>Odds ratio for Forensic versus Clinical</b>
Has made an ESA recommendation for one or more individuals <sup>†</sup>	9 (18.0)	18 (50.0)	27 (31.4)	4.6*
Believes it is appropriate for a treating mental health professional to offer an opinion on the need for an ESA <sup>α</sup>	37 (77.1)	29 (80.6)	66 (78.6)	1.2
Feels qualified to make an ESA determination <sup>α</sup>	32 (65.3)	22 (62.3)	54 (64.3)	0.9

*Note.* \* $p < .01$ . <sup>†</sup> One individual refused to answer this question resulting in a total  $N$  of 86 for this item. <sup>α</sup> Three individuals refused to answer these items which resulted in a total  $N$  of 84. ESA = Emotional support animal. The clinical group was the reference group for the odds ratio analyses.

