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Grzanka, P. R., DeVore, E. N., Frantell, K. A., Miles, J. R., & Spengler, E. S. (in press). Conscience clauses and sexual and gender minority mental health care: A case study. *Journal of Counseling Psychology.* doi:10.1037/cou0000396

Conscience Clauses and Sexual and Gender Minority Mental Health Care: A Case Study

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The second and third authors contributed equally to this manuscript and are listed alphabetically. This research was supported by a Local- and State-Level Policy Work Grant from the Society for the Psychological Study of Social Issues. An earlier version of this paper was presented at the 2019 American Psychological Association Convention. The authors wish to thank Christopher Sanders and Leticia Y. Flores, Ph.D., for their collaborative efforts to make this study possible.

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Abstract

Tennessee is one of the first states in the United States to have a law that enables counselors and therapists in private practice to deny services to any client based on the practitioner's "sincerely held principles." This so-called 'conscience clause' represents a critical moment in professional psychology, in which mental health care providers are on the frontlines of cultural and legal debates about religious freedom. Though the law's language is ambiguous, it was widely perceived to target sexual and gender minority (SGM) individuals. We interviewed 20 SGM people living in Tennessee to understand their experiences with mental health care in the state and their perceptions of the law. Our participants perceive the law as fundamentally discriminatory, though they overwhelmingly conceptualize the conscience clause as legalizing discrimination toward members of all stigmatized groups—not just SGM individuals. They described individual and societal consequences for the law, including an understanding of the conscience clause as harmful above and beyond any individual discrimination event it may engender. We situate these findings amid the research on structural stigma and suggest that counseling psychologists become actively engaged in combatting conscience clauses, which appear to have profound consequences on mental health care engagement, particularly for populations vulnerable to discrimination.

Keywords: mental health care, discrimination, law, conscience clause, ethics

Public Significance Statement: This study explores the consequences of a law in Tennessee that may legalize discrimination in therapy. The authors elaborate how "conscience clauses" may discourage members of vulnerable groups from seeking therapy, which may exacerbate the effects of social stigma on individual mental health.

Conscience Clauses and Sexual and Gender Minority Mental Health Care: A Case Study

Though the Supreme Court decision in *Obergefell v. Hodges* (2015) legalized same-sex marriage in the United States, the legal status of sexual and gender minority (SGM[1]) individuals is hardly equal to that of heterosexual and cisgender people. For example, lesbian, gay, bisexual, and transgender (LGBT+) individuals still lack legal protections from discrimination in housing and work in 31 states (HRC, 2018). Further, state and federal lawmakers regularly introduce legislation designed to legalize discrimination toward SGM people, including laws that restrict transgender individuals' bathroom access and enable religious organizations to deny adoptions to same-sex couples (Allison & Garcia, 2019). Under the Trump administration, the Department of Health and Human Services announced a regulation that would allow health care providers to cite their religious beliefs as grounds for refusing to serve patients, a move broadly interpreted as targeting SGM people (Clymer, 2019). This religious exemption policy is just one example of a range of so-called "conscience clauses" at the center of policy debates about whether religious beliefs should supersede antidiscrimination laws, ethical codes, and unwritten social and cultural norms about private citizens' access to everything from health care to wedding cakes (Geidner, 2019). In Tennessee, for example, counselors and therapists in private practice have been legally allowed to deny services to clients based upon the therapist's "sincerely held principles" since April 2016 (Tenn. Code Ann. § 63-22-302, 2016). Though as of September 2019 no client has publicly attested to being refused services in Tennessee because of the law, existing research on anti-SGM legislation (e.g., Hatzenbuehler, Keyes, & Hasin, 2009) raises important questions

[1] "Sexual and gender minority" denotes all individuals who are not cisgender and heterosexual. We generally use SGM throughout this manuscript to acknowledge sexual orientation and gender manifest in ways that exceed the limits of the LGBT acronym. When we use LGBT or other similar abbreviations (e.g., LGBTQ, LGBT+), we are referencing the particular population in the cited research or the language of an original source.

about the consequences of this law— one of the first of its kind—and the others like it that appear inevitable given the landscape of contemporary American politics (Veldhuis, Drabble, Riggle, Wootton, & Hughes, 2018).

The present inquiry explores the often-invisible consequences of institutional discrimination, including how legalized discrimination may affect even those who have not directly experienced discrimination. We focus on the conscience clause in Tennessee for several reasons. Unlike other conscience clauses, it accordingly affects practicing counselors and therapists, as opposed to trainees. For example, a 2011 law in Arizona allows students in essentially all mental health training programs to claim religious exemption and avoid working with certain clients (Wise et al., 2015). Psychologists have documented how, even though conscience clauses tend not to specify a client population, the values conflicts behind them are typically motivated by religiously conservative individuals seeking the option to not serve SGM clients (Mintz et al., 2009). High-profile public debate about the Tennessee legislation focused on how what came to be known as the "Counseling Discrimination Law" (Grzanka, Spengler, Miles, Frantell, & DeVore, in press) targeted SGM individuals, even though the law's architects refused to acknowledge any discriminatory intent or include language in the bill that specified which kinds of clients might cause a therapist to deny services (Plazas, 2016). Furthermore, because the Tennessee law is one of the first statewide conscience clauses for licensed mental health care providers (Green, 2016), little is known about how such policies might affect the help-seeking practices of its imagined targets (i.e., SGM people) and/or how such laws affect SGM individuals' perceptions of mental health care and therapists. With a purposefully derived subsample (N = 20) of adult SGM respondents in Tennessee who completed a survey about their attitudes about the law and their help-seeking behaviors (Grzanka et al., in press), we conducted

interviews focused on how SGMs actually experience the law and its effects. Our findings indicate that our respondents perceived the law as fundamentally discriminatory (as opposed to protecting therapists) and as potentially harmful to an expansive population of marginalized and socially stigmatized individuals. Our results may inform psychological research on conscience clauses, as well as psychologists' advocacy about these policies, which represent an understudied and fraught issue in professional psychology.

Structural Stigma and Mental Health Care

The question of how the conscience clause in Tennessee affects SGM individuals, who may or may not be experiencing discrimination from health care providers, implicates a number of interrelated issues, including minority stress writ large, the structural, practical, and psychological effects of discriminatory legislation, sexual prejudice and cisgenderism in psychotherapy, and psychology's complex relation to conscience clauses. We situate these domains in the context of Tennessee's especially hostile climate for SGMs. Indeed, this law is hardly the only one that has buttressed what Hatzenbuehler (2009) termed "structural stigma" for SGM people in the United States.

Minority Stress in Structural Relief

Meyer's (2003) extensively documented minority stress theory stipulates that stigmatized groups' social positioning often results in excess distal and proximal stressors which, in turn, result in health problems and other inequities relative to dominant group members. Hatzenbuehler's (2009) closely related psychological mediation framework likewise suggests that individuals cope with these stressors in different ways. Accordingly, a range of factors including existing mental health issues, social support, and personality variables mediate the relation between discrimination and mental health outcomes. Dimensions of difference such as

social identities (e.g., race, religion, social class) may function as moderators. While sociologists have effectively always studied the structural elements of oppression (e.g., Collins, 2000), Hatzenbuehler (2009) notably operationalized structural stigma (in psychology) as relative levels of homophobic prejudice as indicated by law, public opinion, and other empirically assessable metrics. However, he later broadened the scope of psychological research on structural stigma to include societal-level discrimination toward virtually any stigmatized group, including racial and ethnic minorities (Hatzenbuehler, 2016). Hughto, Reisner, and Pachankis (2015) likewise identified structural stigma as a determinant of health outcomes for gender minorities.

Laws that enhance or constrict civil rights to certain groups appear to affect the mental health and well-being of those groups. For example, LGB individuals living in states that did not extend legal protections to them were more likely to receive a diagnosis of dysthymia, generalized anxiety disorder, post-traumatic stress disorder, and substance use disorder than LGB individuals living in states with legal protections and heterosexual people living in either states with or without laws affording legal protections to LGB people (Hatzenbuehler et al., 2009). In states that legally banned same-sex marriage, there was a significant increase between the year before the ban to the year after the ban in all mood disorders (36.6% increase), all alcohol use disorders (41.9% increase), generalized anxiety disorder (248.2% increase) and psychiatric comorbidity (36.3% increase) among LGB people (Hatzenbuehler et al., 2010). Haztenbeuhler and colleagues found no significant increase in psychiatric disorders for LGB people living in states without discriminatory constitutional amendments.

Empirical research continues to demonstrate anti-SGM legislation is associated with negative mental health outcomes for SGM people. In response to Proposition 8, a California ballot initiative that ultimately rescinded the right of same-gender couples to marry, SGM

individuals reported conflict with family and the "larger heterosexual community," and described how anticipation of the law passing contributed to minority stress (Maisel & Fingerhut, 2011). Similarly, Rostosky, Riggle, Horne, and Miller (2009) found minority stress significantly predicted psychological distress for LGB adults in states that passed anti same-sex marriage amendments. Although legislation negatively impacts the mental health of sexual minority individuals, the passing of affirming laws has been linked to *decreased* levels of distress. Among sexual minority men, diagnoses of depressive, anxiety, and adjustment disorders decreased the year following legalization of same-sex marriages in Massachusetts (Hatzenbuehler et al., 2012). Among sexual minority women, lower levels of depressive symptoms, perceived discrimination, and stigma consciousness were associated with the presence of pro-civil-union legislation (Everett, Hatzenbuehler, & Hughes, 2016). A key theme in this literature is that discriminatory legislation does not have to personally affect SGM people in order to negatively impact SGMs in that law's jurisdiction. In other words, the laws appear to be harmful just by their very existence—regardless of whether or not the laws are actually invoked to practice discrimination.

Conscience Clauses

Tennessee has been a laboratory of sorts for conservative legislation that is expressly or covertly discriminatory toward SGM people. Within the past decade, proposed legislation has included the "Don't Say Gay" bill (failed; Fallon, 2013), which would have prohibited any discussion of same-sex relationships in public schools and required teachers to out sexual minority students to their parents; an anti-transgender "bathroom bill," which would have allowed the state's attorney general to defend any school supporting policies assigning bathrooms based on sex at birth (failed; Buie, 2018); and most notably, the counseling conscience clause (passed; Tenn. Code Ann. § 63-22-302, 2016), which allows clients to be

denied therapeutic services if the client's "goals, outcomes, or behaviors" conflict with the therapist's "sincerely held principles." Notably, the phrase "sincerely held principles" is the modified version of the bill's earlier language of "sincerely held religious beliefs" (Locker & Meyer, 2016). The law's location in the state's code (i.e., Chapter 22) means that it applies to counselors and marriage and family therapists (Green, 2019), though the actual language of the law does not specifically exclude psychologists nor does this distinction bear much weight for the lay public, including clients. Defenders of the law underscored its provision that in all cases *except* that of a suicidal client, in which clients cannot be turned away, providers invoking the law are required to make a referral to another provider (Plazas, 2016). Critics noted, however, that referrals are not always practical or feasible in Tennessee, which has a large rural population outside of the state's five major metropolitan regions. The law's proponents, including then-Governor Bill Haslam, refused to state publicly that the law was designed with SGM clients in mind; however, activists throughout the state, including the state's largest LGBT equality organization, the Tennessee Equality Project, perceived the law to be motivated by sexual and gender prejudice (Green, 2016; Plazas, 2016). Further, the law directly violates the ethical codes of the American Psychological Association (APA, 2010) and American Counseling Association (ACA, 2014a); both organizations have issued statements reproaching similar laws because they violate ethical obligations to provide competent care to all clients and engage in nondiscriminatory practice (ACA, 2014b; APA, 2016; Rudow, 2011; Wise, Bieschke, Forrest, Cohen-Filipic, Hathaway, & Douce, 2015).

Psychologists and other mental health care providers have been implicated in the rise of conscience clauses since the legalization of abortion in the U.S. in 1973 (see Berlinger [2008] for an overview of conscience clauses in health care writ large). The APA, ACA, and other relevant

professional organizations are functionally compelled by the law to negotiate conscience clauses as a delicate balance of inclusive principles and free speech protections for individual therapists and trainees (Wise et al., 2015). However, the complex ethical and legal issues endemic to conscience clauses historically represented a proverbial black box for professional psychologists, particularly as the APA found itself reacting to conscience clause legislation in the early 21st century. Could training programs legally expel a student who used religious beliefs to justify belief in conversion therapy? What about a student who cited religious beliefs to avoid certain coursework or client issues (e.g., infidelity)? Notably, the most prominent legal cases and legislative attempts to legalize conscience clauses in mental health care had—at least before the Tennessee law—focused on trainees, as opposed to licensed practitioners. In response to these cases (*Keeton v. Anderson-Wiley,* 2012; *Ward v. Willbanks,* 2010) and the 2011 Arizona law (H.B. 2565, 2011) that allows trainees to refuse to see certain clients, the APA convened a virtual working group in 2011 to study restrictions affecting diversity training in graduate education. The working group reasserted psychology's compelling interest in meeting the needs of a diverse client population, a compelling interest that may come in conflict with trainees' and mental health professionals' personal beliefs. Wise et al. (2015) also suggested training programs should respond consistently to issues arising from tensions between trainees' personal beliefs and requisite professional competencies so as not to single out particular religions and thereby "alleviating claims of religious discrimination" (p. 263). Finally, they asserted that ability to work with a diverse client population is not an optional competency for trainees and provided sample pedagogical statements and program policies to assist training programs as they navigate these kinds of conflicts with trainees.

The working group's findings represented an important moment of clarification with regard to professional psychologists' relationship to religious exemptions in mental health training, but none of the recommendations were legally binding nor represented formal changes to APA's ethics code (Wise et al., 2015). Further, though the document implicates licensed psychologists via its emphasis on professional competencies and serving the public good, Wise et al. do not directly address religious exemptions for licensed practitioners. Tennessee's conscience clause is notable for many reasons, not the least of which is that it applies to counselors and therapists in private practice, potentially affecting far more therapists and clients than religious exemption laws affecting trainees (e.g., Arizona's H.B. 2565, 2011). Nevertheless, consistent with controversy about the Tennessee law (Plazas, 2016), Wise et al. focused on LGBT people as the prototypical subjects of attempts to seek religiously motivated exemptions in psychological training. Conscience clauses are a vexing issue with potential consequences at both individual/practical and structural/community levels. For example, these laws may discourage SGM individuals from seeking mental health care. The treatment gap for SGM people is well documented, as are the experiences of microaggressions, incompetence, and care refusal experienced by SGM individuals who seek health care (e.g., Hughto, Murchison, Clark, Pachankis, & Reisner, 2016). Additionally, these laws may legitimate social stigma, increase minority stress, and exacerbate the structural issues that already discourage some SGM individuals from seeking health care (Grzanka et al., in press; Dalhamer, Galinsky, Joestl, & Ward, 2016).

SGMs and Mental Health Care Services

It is well established that SGM people utilize psychotherapy more often and for greater lengths of time when compared to their heterosexual counterparts (Grella, Cochran, Greenwell,

& Mays, 2011; Grella, Greenwell, Mays, & Cochran, 2009; Liddle, 1997; Platt et al., 2018). Inequitable mental health rates related to minority stress (Meyer, 2003; Tebbe & Moradi, 2016; Lefevor, Boyd-Rogers, Sprague, & Janis, 2019) may be one reason SGM individuals seek psychotherapy services at higher rates than their straight counterparts (Liddle, 1997; Grella, Cochran, Greenwell, & Mays, 2011; Grella, Greenwell, Mays, & Cochran, 2009; Platt, Wolf, & Scheitle, 2018; Spengler & Ægisdóttir, 2015). However, higher rates of mental health care utilization do not necessarily mean that all SGM individuals who want or need mental health care pursue it. Indeed, compared to heterosexual individuals, sexual minorities report more barriers to health care (Dalhamer et al., 2016) and more unmet mental health care needs (Burges, Lee, Tran, & van Ryn, 2008). Further, that some SGM individuals seek mental health care does not mean that psychotherapy is always affirmative (Shelton & Delgado-Romero, 2011). Differential treatment of SGM clients in therapy is evidenced by pathologizing diagnoses (Biaggio, Roades, Staffelbach, Cardinali, & Duffy, 2000; Eubanks-Carter & Goldfried, 2006; Moleiro & Pinto, 2015) and more subtle forms of discrimination, including microaggressions (Nadal, Skolnik, & Wong, 2012; Nadal et al., 2011; Spengler, Miller, & Spengler, 2016).

Diagnosis and treatment. Therapists may view SGM clients differently compared to their heterosexual or cisgender clients (e.g., less favorable ratings [Barrett & McWhirter, 2002], endorse stereotypes [Mohr, Chopp, & Wong, 2013]), or offer differential diagnosis and treatment determinations. For example, research has documented therapists recommending medication more (Biaggio et al., 2000) and diagnosing borderline personality disorder differently depending on gender or sexual orientation (Eubanks-Carter & Goldfried, 2006). In some cases, differential evaluation can seem positive, such as when LG clients were described as functioning better in their relationships and being more motivated for therapy (Biaggio et al., 2000). However, this

systematic difference in evaluation could lead to clinical errors and discrimination (e.g., when a therapist invalidates a gay client presenting with relationship concerns; Spengler et al., 2016).

Microaggressions. Much of the discrimination that SGM clients experience in therapy is subtle but nonetheless consequential. Microaggression research has exposed the negative impacts of hostile and derogatory messages—whether intentional or unintentional—that are directed at members of historically marginalized groups through verbal, behavioral, and/or environmental indignities (Nadal, Whitman, Davis, Erazo, & Davidoff, 2016; see also Platt & Lenzen, 2013). Shelton and Delgado-Romero (2011) examined the microaggressions LGBQ individuals experienced in therapy and found seven themes: (1) assumptions that sexual orientation is the cause of all presenting concerns, (2) avoidance and minimization of sexual orientation, (3) attempts to overidentify with LGBQ clients, (4) making stereotypical assumptions, (5) expressions of heteronormative bias, (6) assumption LGBQ people need therapy, and (7) warning about the dangers of LGBQ identity. Other research has echoed (Berke et al., 2016; Kelley, 2015; McCullough et al., 2017) or added to (Smith & Shin, 2014) this list.

Microaggressions have been linked to increased risk for mental health concerns among LGBT people (Nadal et al., 2011; Sarno & Wright, 2013; Woodford et al., 2015) and the expression of these microaggressions in the therapy room can have detrimental effects on the clinical relationship (Morris, Lindley, & Galupo, in press; Owen, Tao, & Drinane, 2018) and mental health service engagement (Hood, Sherrell, Pfeffer, & Mann, 2018; Liddle, 1996; Spengler & Ægisdóttir, 2015). Conversely, LGB participants reported a greater likelihood of returning to therapy, willingness to disclose information, willingness to disclose sexual orientation, and positive therapist ratings when the therapist used more affirming language and did not display heterosexist attitudes (Dorland & Fischer, 2001). Psychologists have also

documented how trans and non-binary individuals experience microaggressions, harassment, and maltreatment across registers of social life, including health care (Watson, Allen, Flores, Serpe, & Farrell, 2019). Notably, little of this research takes an intersectional approach to explore how other dimensions of clients' (and therapists') identities may shape the form, content, and experience of microaggressions in therapy (Budge, Israel, & Merrill, 2017; Grzanka & Miles, 2016).

SGM preferences for therapists. Perhaps because SGM clients experience clinical discrimination frequently, several studies have identified therapist characteristics preferred by SGM clients (Burckell & Goldfried, 2006; Israel, Gorcheva, Burnes, & Walther, 2008; Kelley, 2015; Liddle, 1996, 1997; McCullough et al., 2017; Quiñones, Woodward, & Pantalone, 2015). Many SGM clients seek LGBT-affirmative therapists (Burckell & Goldfried, 2006; Kelley, 2015; Liddle 1996, 1997) or someone who generally understands the LGBT experience (Burckell & Goldfried, 2006; Quiñones et al., 2015). Therapists who engage in non-affirming practices were seen as less helpful and often corresponded with early termination (Liddle, 1996). This is so important, in fact, that many clients will seek out referrals from friends, family, or community organizations or ask about the reputation of a therapist before seeking services (Liddle, 1997; McCullough et al., 2017). Clients also seek general therapeutic competence (Israel et al., 2008; Quiñones et al., 2015), indicating that they want a therapist who is empathic, non-judgmental, and able to work toward goals. Though increased training in SGM issues can have positive results for both the therapist and subsequently their clients (Graham, Carney, & Kluck, 2012; O'Shaughnessy & Spokane, 2012; Pepping, Lyons, & Morris, 2018), many therapists and trainees report they do not have sufficient training in knowledge or skills for working with SGM clients (Allison, Crawford, Echemendia, Robinson, & Knepp, 1994; Ebersole, Dillon, & Eklund,

2018; McGeorge & Carlson, 2014; Phillips & Fischer, 1998; Scherrer, 2013; Sherry, Whilde, & Patton, 2005). Training and resources do exist (APA, 2012; APA, 2015; Fredriksen-Goldsen, Hoy-Ellios, Goldsen, Emlet, & Hooymen, 2014; Hope & Chappell, 2015; Kolmes & Witherspoon, 2012; Solomon, Heck, Reed, & Smith, 2017) and are related to increased competency and self-efficacy working with SGM clients (Alessi, Dillon, & Kim, 2015; Graham et al., 2012; O'Shaughnessy & Spokane, 2012; Owen et al., 2018; Pepping et al., 2018). However, some have critiqued the extent to which LGBT-affirmative paradigms actually help therapists address the structural, intersectional issues facing diverse SGM clients (Grzanka & Miles, 2016; Moradi, 2017).

Current Study

Quantitative evidence suggests anti-LGBT laws (e.g., bans on same-sex marriage) negatively impact the mental and physical health outcomes of SGM people (Hatzenbuehler et al., 2009, 2010, 2014; Fingerhut & Maisel, 2011) and that SGM people seek mental health services at higher rates than their cisgender and heterosexual counterparts (Liddle, 1997; Grella et al., 2009, 2011; Platt et al., 2018). The current study represents the second phase of a two-part sequential mixed-methods study of the conscience clause in Tennessee (Tenn. Code Ann. § 63-22-302, 2016), which allows practitioners in private practice to deny services to clients based on practitioners' sincerely held principles (Grzanka et al., in press). In the first phase of survey-based data collection, we found that, among 364 SGM people living in Tennessee, awareness of the law was pervasive. Further, we observed significant associations between potential conscience clause-type legislation and participants' willingness to seek therapy, psychological distress, and perceptions of mental health care providers. Further, our respondents who were aware of the law and highest in LGBT+ group identity were most likely to engage in practices of

self-concealment (i.e., strategic closeting) than those unaware of the law. Conversely, those unaware of the law and highest in LGBT+ group identity reported significantly lower levels of psychological distress than those lower in LGBT+ group identity who were similarly unaware of the law. Cumulatively, our findings suggested that those lower in LGBT+ group identity were more likely to self-conceal than their higher LGBT+ group identity peers; nevertheless, consistent with prior findings, awareness of the law minimizes the differences in reported psychological distress among those with various levels of LGBT+ group identity. Finally, when asked to define "sincerely held principles" in an open-ended question, the majority of respondents wrote something about "religion" and "beliefs," reflecting the original language of the bill.

Though phase one (Grzanka et al., in press) offered insight into how the conscience clause may function for SGM Tennesseans as a form of structural stigma, our survey research and the bulk of extant literature on conscience clauses is unable to discern how SGM individuals actually make meaning about laws of this kind. Accordingly, to reveal nuances in experiences that are fundamentally effaced by brief online survey research, we asked respondents in phase one if they would be willing to participate in a follow-up interview. A purposively derived, diverse sample of respondents (N = 20) participated in interviews with the five members of our research team. Our organizing research questions were: (1) *What are our respondents' perceptions of mental health care services in the state?* (2) *Have they or people they know experienced discrimination in mental care settings?* (3) *How do they understand the conscience clause law and its implications for both themselves and others seeking mental health care?*

Method

Overview

The study was approved by the Institutional Review Board at The University of Tennessee, Knoxville. A total of 168 survey respondents from phase one (Grzanka et al., in press) agreed to be contacted and provided contact information. Respondents were contacted via email and asked to schedule an interview with one of five research team members who conducted all interviews over the phone with videoconferencing software during summer 2017.

Positionality/Standpoint

Our constructionist approach is informed by feminist standpoint theory, which rejects facile definitions of scientific "bias" and instead seeks to name and interrogate the embodied subjectivities of researchers, who are active participants in the knowledge production process (Haraway, 1988; Hesse-Biber & Piatelli, 2007). Further, our methodology was guided by principles of feminist qualitative interviewing (DeVault & Gross, 2012), which emphasize critical attention to power and ethics above and beyond normative disciplinary standards. The research team is composed of two faculty members and three doctoral students in counseling psychology at a research-intensive public university in the Southeastern United States. The team members represent diverse sexual orientations, genders, social class backgrounds, and religious orientations; all are White and none identifies as disabled. In addition to these embodied social identities, our political orientations are central to the standpoints we brought to our study design and data analyses. We launched our study in collaboration with Tennessee's statewide LGBT equality organization and took an explicit social justice approach to our work, though that advocacy organization did not have any input on the kinds of questions we asked, study design, or data analysis. We sought to accurately and fairly document any harm that the conscience clause may have done to our respondents. Nonetheless, we were prepared and committed to uncovering unexpected results and used an iterative, team-based approach to interviewing and

coding so that we would maximize the opportunity for unanticipated discoveries, including participants' experiences that are politically incongruent with our own.

Participants

Survey participants were recruited via snowball sampling and targeted advertising to diverse communities and organizations throughout the state of Tennessee, including rural LGBT+ organizations and organizations that focus on communities of color. Recruitment emails identified the researchers as "a group of psychologists conducting a study on LGBT+ Tennesseans' beliefs about psychological services and their perceived barriers to help-seeking." This process yielded 168 individuals 18 or older who consented to be contacted by our team; participation was not incentivized. We divided these 168 participants equally among the five team members and took a purposive approach to sampling whereby we sought to maximize diversity in terms of race, gender, sexual orientation, and region of the state. Saturation was defined *a priori* as achieving a diverse sample of respondents whose experiences represented a range of perspectives that converged on identifiable themes with increasing consistency. Participant demographics, including their pseudonyms, are detailed in Table 1. Their ages ranged from 18 to 67. To protect participant anonymity, we report only the region of the state in which they reside, rather than city/town.

Procedures

Participants were provided an informed consent memo via email prior to the actual interview; consent was indicated by having received and read the form. All interviews were conducted over the phone or via videoconferencing software and audio was recorded digitally. Demographic information was collected during the interviews (Appendix), which lasted 14-42 minutes. Because the consent process was fully transparent (i.e., participants knew the purpose

of the interview), no debriefing process was required. Participants were thanked for their time at the conclusion of the interview and informed of an online list of therapists in Tennessee who pledged not to discriminate against their clients.

Analysis

All interviews were professionally transcribed and then reviewed by team members for accuracy. Analyses were guided by principles of thematic analysis (Braun & Clarke, 2006; Braun & Clarke, 2012) and best practices for qualitative research in psychology (Levitt et al., 2017), including longstanding emphases on trustworthiness (Morrow, 2005). We opted for a thematic analytic approach, as opposed to critical discourse analysis (Clarke, 2005), the extended case method (Burawoy, 1998), or grounded theory (Fassinger, 2005) for a number of reasons. First, we were too familiar with the situation of inquiry and extant research on conscience clauses and structural stigma to even attempt a naïve relationship to our data, suggesting that an explanatory theory fully grounded in our data would be unrealistic (Fassinger, 2005). However, we nonetheless aimed for an inductive account of our participants' experiences. Though we conceptualized the Tennessee conscience clause as a case of a widespread phenomenon (Luker, 2008), Burawoy's (1998) approach is best suited to testing existing theory, to which our relatively brief interviews were not well suited. Similarly, critical discourse analysis lends itself to analyses that focus on latent meanings in the data (Clarke, 2005), whereas our research questions were organized around transparent reporting of participants' perspectives. Accordingly, thematic analysis's theoretical flexibility, inductive orientation, and straightforward coding procedures matched our data and research objectives (Braun & Clarke, 2006).

After each interview, interviewers would memo and share (via email) initial reflections on the interviews to the group; this process was critical to determining saturation so that research

team members were in constant communication during data collection. The second and third authors shared responsibilities for developing the initial coding list that included seven major themes, which were shared with the group and independently audited by the three remaining team members, who provided feedback based on their own interviews and reviews of all transcribed interviews. Revisions were incorporated and a master code list was created in NVivo 12; each of the team members coded interviews that were arbitrarily assigned across the group. Modifications to the coding schema were made iteratively and discussed over email, in in-software memos, and at regular team meetings. Ultimately, once all interviews were coded, they were then reviewed by the second and third authors. The first and fourth authors served as primary auditors and the first author provided extensive feedback on descriptions of the themes, which are annotated in our results presented here. No existing theory was used to develop the codes or themes; reflection on the connections between our data and existing research was contained to the manuscript preparation process.

Results

Nine higher order themes and 14 subthemes emerged. The higher order themes included: *Tennessee Values, Meaning of the Law, Perceived Effects of the Law, Mixed Reactions to Law, Consequences of Not Seeking Mental Health Care, Experience with Therapy Providers, Qualities of a Therapist/Safe Provider, LGBT+ Needs,* and *Ways to Support LGBT+ People.* Notably, these themes do not only represent commonly articulated ideas in the dataset but those concepts—regardless of their frequency—that offered insight into participants' understanding.

Tennessee Values

Participants described a variety of values associated with living in Tennessee, including Southern hospitality, being in the "Volunteer State," and references to regional (i.e., West,

Middle, or East Tennessee) differences. Jacob (21, White, cisgender man, asexual, Catholic, Middle Tennessee resident) explained, “Tennessean, it’s just, well it’s part of where you come from, but it’s also a culture on its own. It’s very Southern and hospitable and neighborly.”

Participants described how the law matched their overall perception of Tennessee. Brittany (41, White, cisgender, gay woman, Protestant, West Tennessee resident) said, “Tennessee has always kind of felt like a place that would have a law like that, I think that’s part of why I wanted to move away when I went to college, because I never really felt like I fit in here.” Other participants described how this law conflicted with their Tennessee values, as Julie (31, White, cisgender woman, bisexual, agnostic, East Tennessee resident) stated, “It [the law] does not align with my values as a Tennessean. The law, I think it is the antithesis of giving unto others in the sense of ‘The Volunteer State.’” This theme contradicts the idea that the law represents and protects Tennesseans’ values; more than half of participants saw the law as unconscionable and incongruent with “what it means to be a Tennessean.” Moreover, Emma (34, White, cisgender woman, bisexual, Pagan, Middle Tennessee resident) said “I don’t see how the law really should align with anybody’s values, to be honest.”

Meaning of the Law

Because the conscience clause law was characterized by legislators as non-religious and not specifically targeting a single group (e.g., Dobuzinskis, 2016), we wanted to know how participants defined “sincerely held principles” in the context of the law. Most participants identified the law as religiously based and targeting multiple groups including, but notably not limited to, SGM people. We identified two subthemes: *Ambiguous Meaning* and *Religious Discrimination.*

Ambiguous Meaning. Participants noted that the law was generally unclear, as Zachary (35, Hispanic/Latino, cisgender man, gay, Christian/Catholic, Middle Tennessee resident) shared: "I think it could mean a lot of things. It's a loose term, but I think it's hard to define exactly. Depends on who you ask, you're going to get a different answer every time, so I think it's a problem with that type of language." Jacob noted that while the law seemed to be religious, it was still difficult to interpret, "…from my understanding, it is a law that allows counselors to deny service to anyone who they believe violates their religious beliefs, which is very general and somewhat vague."

Religious Discrimination. Other participants felt "sincerely held principles" was code for religious-rooted discrimination. Savannah (31, White, cisgender woman, asexual, "vaguely Christian-ish but raised Southern Baptist," Middle Tennessee resident) explained that sincerely held principles meant, "…religious beliefs. They don't want to counsel anyone that deviates from their view of how one should live." Although nearly all participants viewed the law as a tool for discrimination against SGM people, participants also keenly understood the law to be a tool to enshrine religious values into law.

Participants also defined the law as state-sanctioned discrimination against SGM people or people who conflict with Christian beliefs. Charles (49, White, cisgender man, gay, non-denominational Christian, Middle Tennessee resident) said:

> Like, if I were a therapist or a doctor, and I were a racist, there is no sort of recognized or generally accepted standard, by which I could discriminate someone based on their race. But because it's widely held among many religions that denying the gender that God made you, or acting on your same-sex attraction, is against the law of God. Based on religious freedoms, they're able to claim that foundation as a source…as a justification

> for discrimination. So, the firmly held beliefs as I see is [*sic*] religious beliefs that are contrary either to same-sex attraction, or trans identity.

As Savannah plainly stated: “They want to ignore the LGBT community as much as they can. I think that was the intended consequence whether they would state that or not.”

Perceived Effects of Law

Rather than exclusively an individual or SGM issue, participants demonstrated an acute awareness of how the law could affect structural dynamics in mental health care for a wide range of individuals from different social groups. We identified three subthemes: *Lack of Safety in Therapy, Reducing and Deterring Mental Health Care,* and *Slippery Slope.*

Lack of Safety in Therapy. A minority of participants described how the law produces increased stigma, heterosexism/transphobia, and internalized heterosexism/transphobia, which extend into the therapy room. Clients may feel more pressure to disclose their identity early to determine if their therapist is safe or to withhold their identity for fear of rejection. Brittany said:

> I would have gone, or probably actually would have gone and not come out to them. I would have tried to keep that a secret, and that would have just destroyed my ability to talk open [*sic*] with them, and probably wouldn't have made any progress with them. That's most likely what would have happened.

Reducing and Deterring Mental Health Care. Participants shared their fears that the law limits services to SGM and other populations (e.g., Muslims), while also deterring people from seeking services. Darling (18, White, gender fluid, androsexual, spiritual but raised Catholic, Middle Tennessee resident) said: “…people would have to drive miles and miles and miles just to get to somebody who would say yes and would treat them because the person who is local is like, ‘Sorry, it's my personal preference, I don't like you.’ Which is bullshit.”

Slippery Slope. Participants almost universally perceived the law as having broad effects beyond an individual client. When asked whom the law could affect, Abby (33, White, cisgender woman, bisexual, no religious identity stated, West Tennessee resident) explained:

> Religious minorities, Muslims and other religions that are not as prevalent, especially in the South, in Tennessee. I think…I don't know, really just anybody with an alternative lifestyle I guess….Anybody that falls outside of the norm of what the ideal Christian, heterosexual marriage and family structure looks like. Divorcees, for instance. A lot of people. I guess it could extend really far if you really wanted to think about it.

Simon (34, White, cisgender man, gay, non-religious/Episcopal, West Tennessee resident) thought the law could be used to discriminate against unwed mothers and African Americans, though he stressed that he perceived there to be no limit to whom the law could affect.

Others feared that this law set a precedent for future anti-LGBT laws. Andy (31, Hispanic, cisgender gay man, Christian, East Tennessee resident) expressed his fear: "…it's discrimination, and that could pass on to other things where maybe other protections will be taken away. Things that we've started fighting for, maybe going back to worse." Andy exemplified our participants' anticipation of discrimination and hypervigilance, which are hallmarks of minority stress (Meyer, 2003). Darling similarly expressed an expansive view of the law's intent and consequences:

> …some mean, tight assed, White person, who's probably a Republican, had the idea of, 'Oh, I know, I'm going to screw with other people who I deem to be below me because I like being on top of things.' When they create the law, they know it's bad and they don't care, because they just want to fuck shit up.

Mixed Reactions to Law

Participants described a spectrum of personal reactions to the law. Some explicitly objected to the law, while others described more of a complacent reaction. In other words, though all participants generally evaluated the law negatively, not all expressly opposed it. Some of these reactions were emotional responses, and others were behavioral. Three subthemes emerged: *No Reason for the Law, Activism Against the Bill,* and *Expose Discriminatory Therapists.*

No Reason for the Law. A small minority of participants noted that they thought the law was unnecessary or offered a solution to a non-existent problem. Jennifer (32, White, cisgender woman, bisexual, atheist, East Tennessee resident) explained, "So, I'm not sure that the bill really does anything specific. Not specific. Does [*sic*] anything explicitly that, perhaps, a good code of ethics wouldn't also cover."

Activism Against Bill. Nearly half of the participants mentioned their own or others' advocacy or activist efforts against the bill prior to it becoming law. Kara (33, White, cisgender woman, bisexual, atheist but grew up Mormon, Middle Tennessee resident) stated, "We went to rallies on Capitol Hill and we phone banked," while Savannah added, "Pretty much all of our group here and me were e-mailing, calling…the state legislature. Voicing our opinion and getting back those standard form responses." Emma and her wife had attended committee meetings and met directly with legislators; they were both involved in individual and organized advocacy against the law at the time of the interview.

Expose Discriminatory Therapists. One participant described his own rationalization for such a law, noting that it exposes therapists who engage in discriminatory practices. John (67, White, cisgender man, gay, not religious, East Tennessee resident) shared:

> If there's any good thing about the law, it is that if you can identify these bigots and like I said, get them out of the lists of possibilities, and don't waste your time with them, just know, "Hey, this guy's not friendly to gay people and don't bother with him."

Note that he offered this interpretation as a potential benefit to an otherwise harmful law. Similarly, Simon felt that any therapist who invokes the law to deny a client services could not possibly provide competent care to that client. However, Simon thought the law "bullshit" and saw nothing positive about it.

Consequences of Not Seeking Mental Health Care

Ranging from interpersonal harm (e.g., damaged relationships) to intrapersonal harm (e.g., self-harm and/or suicide) to community impact (e.g., decreased work productivity and/or lowered perceptions of the state), our participants perceived negative consequences of SGM Tennesseans choosing to not seek mental health care (because of the law). Though some participants noted the ways in which the law had already or might impact them personally, participants were particularly eager to talk about greater social implications if people who need therapeutic services are unable or unwilling to seek those services. For most participants, it seemed necessary to point out the diversity of groups who could be impacted by the conscience clause, rather than exclusively SGMs. Further, some participants brought up suicide as a consequence of law. Joshua (37, Jewish/White, cisgender man, bisexual, Jewish Conservative, Middle Tennessee resident) said:

> I mean, it's easy to go straight to the extreme, but within the LGBT community at large, and within the youth, suicide is a big problem…I think the personal impact can be as little as unnecessary suffering, which is unacceptable, and as great as the loss of life.

Julie discussed the impact on “society”: “To society as a whole, it just perpetuates a lack of empathy, and action, and resources, for those that may be suffering openly or in silence.”

Experience with Therapy Providers

Participants described experiences with mental health care professionals that were characterized by rejection or positive interactions, and these experiences have implications for how they conceptualized future help-seeking in the context of the conscience clause. Six reported experiencing some kind of discrimination in mental health care. Andy, for example, said:

> I had been diagnosed with depression while I was in college. At this point I had graduated and it was at the peak...I went to a counselor's office because that was the only source that I had. In the beginning, she was trying to get to know me a little bit more, like what have I been through. Then the topic of sexuality came up and I went to a…this was a Baptist school. She wasn't really negative about it, but she was very much against it, and she let me know that she was against it.

Zachary reflected on more positive experiences in counseling. He said, “I think over the third or fourth session it definitely clicked that I can be open and honest here. This is actually normal and this is actually healthy and something that people should do.”

Jessica (38, White, transgender woman, did not disclose sexual identity, currently spiritual but raised Catholic, West Tennessee resident) described terrible experiences in a forced Christian counseling experience while in high school: “It just didn't do any good. It just didn't do anything. It was just eight months of wasted money. And that was the only time I ever went.” Though she did say that she was not “above ever reaching out for help” if she needed it, she was also cognizant of potentially invalidating interactions with therapists, particularly in light of the new law. She specifically highlighted rural areas and Knoxville (a relatively conservative city) as

places where she anticipated SGM clients might experience “problems” getting affirmative mental health care. Emma corroborated Jessica’s speculation when narrating her past therapy experience in a rural area outside of Nashville where there were only two “mental health options in town.” During an intake session, the therapist abruptly stopped Emma and suggested she see another therapist. When Emma pressed for an explanation, the therapist explained that continuing to treat Emma would “be a tacit endorsement” of Emma’s relationship with a woman (i.e., her future spouse) and that the therapist’s “religion was not compatible with that.”

Qualities of a Therapist/Safe Provider

Based on previous experiences with mental health care providers, participants described the ways in which they determine if a care provider is safe. They indicated several qualities that denote safety from a provider, and three subthemes emerged: *General Fit, Clinical Competency,* and *Indication of Allyship or Affirmative Therapy.*

General Fit. Participants described assessing for general fit between themselves and a potential therapist and stated they would consider desired demographic characteristics, shared values, logistics (e.g., insurance accepted, geographical location), and general compatibility. Andy illustrated how this could mean religious compatibility, “Religion, for me, maybe is a little bit important, as far as a counselor, but it’s not absolutely necessary,” while Abby (33, White, cisgender woman, bisexual, no religious identity stated, West Tennessee resident) pointed out that she wanted someone who was not religious, “I definitely don’t want somebody who is conservative or religious in any way.”

Fit also referred to the values a therapist conveys or their attitudes and beliefs about SGM people, as Lee (19, White, agender, transmasculine, asexual, panromantic, Pagan, East Tennessee resident) shared:

> I definitely consider whether or not they're going to be trans-friendly and…some people that [*sic*] are trans-friendly aren't the most accepting of non-binary people so I want to make sure that they are going to accept that. And I also want to make sure that I'm going to be talking to a therapist that doesn't just want to push my sexuality away, blame it on past trauma.

In other cases, fit also referred to general logistics, including cost and location. Zachary noted, "You know, I didn't know who was safe to talk to when I started searching. The way I approached my search was first who might my insurance cover, so cost was a factor for me."

Clinical Competency. Nearly all participants explicitly desired a clinician who demonstrates cultural competency, particularly in terms of SGM issues. They also emphasized the importance of an SGM-affirming attitude, basic empathic counseling skills, ethics, and experience working with the SGM community. Charles said, "I would like my counselor to be free of judgment, a good listener, and very thoughtful at targeting advice, care, homework, to my particular circumstances." Beyond empathic counseling skills, participants regularly expressed a desire for competency in working with SGM people specifically. Alex (35, White/European American, genderqueer, queer, Practitioner of Witchcraft, East Tennessee resident) said, "And also people who have some cultural competency with LGBTQIA issues, just queerness in general, and also an adverse childhood experience [*sic*] and sexual trauma."

Indication of Allyship or Affirmative Therapy. Through referrals, websites, reviewing mission statements, and exploring community reputations, participants determined whether a provider was safe. Participants described using some form of feeling or intuition, including instincts and gut reactions, to determine safety. Simon said "it's one of those things I can't put

my finger on. You know I have to just go with my gut." Jennifer said, "I think it would mostly be a feel," while Jessica explained trusting intuition:

> You know, you can always tell by their office staff, what the general feeling of the office is, you know? And you can tell by the waiting lines. You can tell by the people that are sitting around you what kind of business you're in…It would be like an impression thing. You know, it would be how they held themselves in front of me. And how their office looked, that's a definite representation of what you're going to get.

Further, Abby described practical ways she found providers that would fit her needs:

> I tend to rely on the references from other people…if you're talking specifically about mental health professionals, I think a lot of people have started putting that on their internet profiles or their web pages. A lot of professionals have started putting like they specialize in queer relationships or they specialize in family counseling….

Accordingly, participants used a range of emotional and interpersonal resources, as well as signals from mental health care providers, to determine if a provider is safe and affirmative.

SGM Needs

When asked about the specific needs of SGM Tennesseans, participants emphasized how diverse these needs could be and how SGM Tennesseans may hold multiple identities. For example, half of the participants expressed that SGM people have similar needs to those of who are cisgender or heterosexual. Savannah said:

> Mental health needs of the LGBT are just like the mental health needs of everyone else in general, because lots of people suffer from depression. They suffer from addiction. They suffer from PTSD, from family trauma, all kinds of stuff. Everyone, across the board, has some instances of that regardless of identity.

Savannah stressed that LGBT people are not fundamentally unique in all their mental health care needs. On the other hand, some participants noted there is a need for a space to discuss the within-group diversity of SGM experiences, particularly in terms of pervasive and persistent cissexism in the South. Abby shared:

> …there's still a lot of stigma, especially in the South, surrounding sexual minority and especially gender minority. I think gay and lesbian people are becoming a little bit more accepted in the…society, but transgender people are still very much discriminated against and experience higher rates of depression, anxiety, suicide, violence. It's really sad, and so when you're being persecuted day in and day out, I can only imagine that that just exacerbates a lot of the mental health issues that the normal population may not have….

John noted that a specific mental health need of SMG people in Tennessee is knowing which counselors are receptive to "LGBT clients."

Ways to Support SGM People

Participants provided examples of ways mental health care providers can better support SGM people, emphasizing that providers should put in time and effort to prioritize learning about SGM people and their unique experiences. They described practical ideas for how to support SGM people, which are represented by the following subthemes: *Increase Multicultural Competency (Knowledge, Awareness, Skills), Outreach and Advocacy,* and *Visible Allyship.*

Increase Multicultural Competency (Knowledge, Awareness, Skills). Participants thought practitioners should increase their multicultural competency by spending time and effort engaging in training or learning opportunities to develop their knowledge, awareness, and skills for working affirmatively with the SGM community. Mary (33, lesbian woman, White,

Caucasian, Christian, Middle Tennessee resident) offered a specific situation where she had to educate a provider:

> I think one of the hardest things just in general is having to constantly explain yourself or where you're coming from, or like, "Hey did you know that this law exists?"….If we're thinking about the adoption piece, we're going through fertility stuff right now, and I said that to the doctor, and she was like, 'I didn't realize that [your partner] would have to adopt the child.'

Zachary said providers should talk to people in "the LGBT community just so they can really realize the issues different people have and how these services could be of help to different members of the community." Notably, Zachary emphasized how learning about LGBT people could help mental health care professionals see how *existing* therapeutic skills could be brought to bear on issues facing SGM people as a community.

Outreach and Advocacy. Clinicians should reach out to communities who have a greater need (e.g., rural communities) and engage in efforts to combat systemic and institutionalized oppression. In some cases, participants discussed forging community partnerships; echoing Zachary's point about learning about LGBT communities, Matthew (30, gay man, White, Non-Hispanic, Confirmed Episcopalian, East Tennessee resident) underscored outreach: "Maybe seek out organizations that are led by or involved with the LGBT community to see what needs there are..." Others talked about seeking SGM clients in their own communities. Brittany asserted, "I don't know that a mental health professional would go into a rural area, but it would be nice if they find more support for the people that are in areas where [SGM people] can't find support." Zachary, on the other hand, suggested systems-level advocacy on behalf of SGM people. He challenged mental health care providers "to use their voices, a

community as the association—professional association—to combat anything that [providers] feel would be against the ethics of this profession or this industry."

Visible Allyship. Clinicians can provide visible indications of allyship from recruitment through termination by expressly stating they support and will provide service to SGM clients. Kara explained how this allyship can start before the client walks in the door, "So, it's helpful to utilize those, like the Tennessee Equality Project stickers that says right on your door when you walk in, or right on your website, we don't discriminate according to race, ethnicity, sexual orientation, identification." Allyship may be indicated in the interactions with the therapist or in paperwork, too, as Darling noted, "If it [paperwork] asks questions about sexual history you don't just have heterosexual questions, other questions too are not just like this or that."

Discussion

Our interviews with 20 SGM individuals living in Tennessee yielded insight into both their experiences and perceptions of discrimination in mental health care writ large, as well as their specific conceptualizations of the conscience clause in Tennessee. Consistent with our earlier findings (Grzanka et al., in press), these interviews suggested that our participants perceived the law to be religiously motivated and a tool for discrimination. Though no one in our sample (N = 20) reported being denied services under the law, they explained their objections to the conscience clause and explained how they believe it could harm other individuals and society. Notably, while our participants did conceptualize the law as motivated by anti-SGM prejudice, they believe the law could be used to discriminate against members of virtually any stigmatized group, including religious minorities (i.e., non-Christians) and individuals seeking a divorce or an abortion. No participant said they had been denied services under the conscience clause, but six did say they had experienced some kind of discriminatory interaction in mental

health care, including service denial by a counselor or therapist. Participants also viewed the law in structural terms, whereby members of stigmatized groups in need of care might not pursue help and therefore be vulnerable to exacerbated mental health issues. In addition to seeking training and connections to SGM individuals and communities, participants also suggested that mental health care providers engage in systematic and organized advocacy against conscience clauses.

Our work—really, our participants' volunteered knowledge—contributes to scholarly understanding of the consequences of structural stigma (Hatzenbuehler, 2016). Specifically, our participants expressed their lay beliefs about the psychological *and* sociological consequences of conscience clauses, i.e., the psychosocial ways that conscience clauses may harm communities by their very existence. Our case study qualifies existing quantitative data on the harmful effects of discriminatory legislation (e.g., Hatzenbuehler et al., 2010), which collectively suggests that these laws affect groups who are explicitly or implicitly targeted *regardless* of whether individual group members have specifically experienced the discrimination as a result of the law. In other words, our participants saw the Tennessee conscience clause as discouraging mental health care engagement by virtue of its existence above and beyond the potential for specific discrimination events in mental health care settings. While our findings reflect the growing body of research in this area, ours is the first to qualitatively investigate a law of this kind in which licensed mental health care providers are enabled to deny services. While our objective here was not to "test" minority stress theory (Meyer, 2003), psychological mediation (Hatzenbuehler, 2009), or structural stigma (Hatzenbuehler, 2016), our observed themes reflect empirically documented phenomena in these areas, including hypervigilance, self-concealment, and health care avoidance, as well as resilience and resistance. Though none of our participants had been

denied services under the conscience clause, all saw potentially wide-reaching consequences of the law ranging from individual factors (e.g., distress, suicide) to structural dynamics (e.g., more discriminatory laws, stigma).

Because the Tennessee conscience clause is, as of this writing, the only one to our knowledge that applies exclusively to licensed mental health professionals (e.g., a conscience clause in Mississippi applies to *all* health care providers, including psychologists and counselors; Green, 2016), we know almost nothing about how practitioners perceive it or other conscience clauses, such as those that apply to trainees (Wise et al., 2015). Future empirical work with practitioners could offer insight into how mental health care providers may perceive the law in ways that are consonant or divergent from potential clients. Collaboration with law scholars and those working in the interdisciplinary field of law and society (e.g., Adler, 2018) would surely benefit future counseling psychology inquiry into religious exemptions, as counseling psychologists are generally less prepared to study the nexus of the law and society. Nevertheless, we have attempted to demonstrate here how qualitative psychological inquiry can expose how ordinary citizens make meaning out of laws that have potentially profound material consequences for mental health care and service provision. Our participants spoke at length about how they negotiate seeking affirmative mental health care, as well as the tools they use to identify if a therapist is “safe.” This law and other potential conscience clauses must be incorporated into how psychologists study and conceptualize mental health care utilization among SGM individuals and members of other stigmatized groups (Spengler & Ægisdóttir, 2015), because socially marginalized clients may be anticipating not only microaggressions or clinical errors (Spengler et al., 2016) but legally sanctioned discrimination. Though our case

study of the Tennessee conscience clause is not statistically generalizable, our findings may be analytically generalizable (Luker, 2008) to similar laws in other states and on the federal level.

Further, our case study approach has produced data for advocacy. For example, our research might contribute to future efforts to expose the potential harm of the law (Plazas, 2016). A primary objective of our research was to document harm the conscience clause might cause even before an actual discrimination event or negative clinical encounter, though our findings suggest that discrimination may be relatively routine, at least for SGM individuals seeking mental health care in Tennessee. Our methodology was informed by a commitment to accurately and fairly describe participants' experience of the law, particularly if and how their perceptions differ from our own. For example, one participant saw the law's potential benefit to expose discriminatory therapists; while we might disagree with this logic based on professional ethics for psychologists (APA, 2012) and counselors (ACA, 2014), we acknowledge that some might see legalized care refusal as better than having a client receive incompetent or stigmatizing therapy. Further, our work extends existing scholarship on advocacy. For example, though counseling psychologists have now spent decades developing tools for social justice training and advocacy (Mallinckrodt, Miles, & Levy, 2015), our work offers preliminary evidence that members of the public think we should be advocating against conscience clauses. This finding provides support for Wise et al.'s (2015) recommendation that psychologists take a proactive approach to combatting conscience clause legislation.

In phase one of this study, Grzanka et al. (in press) found that participants defined the "sincerely held principles" language of the law in religious terms and as a way of justifying discrimination. Our findings extend that work insomuch as our SGM participants view themselves *and* others as targets of the law. While we do not have evidence that our participants

conceptualize SGM identities as intersectional (Moradi, 2017), they do think the law has intersectional consequences. For example, abortion was a routine theme in our interviews. In this sense, participants imagined how the law could affect women exercising reproductive autonomy. We did not anticipate that our participants would see the conscience clause as an issue of reproductive justice (Grzanka & Frantell, 2017), a growing area of concern for counseling psychologists. Further, we interviewed several participants who identify as members of extremely stigmatized religious groups, including practitioners of Witchcraft. Though these participants were not concerned about being the targets of religious discrimination, many others were concerned that the law could be used to target religious minorities, as well as those whose beliefs, identities, or behaviors contradict religious norms in Tennessee (i.e., evangelical Christianity). Given that so many perceive the law to be religiously motivated (Plazas, 2016), future work should investigate how conscience clauses affect religious minorities. Likewise, future research should attempt to purposively sample religiously conservative SGM individuals, as well respondents who are unaware of the law.

Despite efforts to recruit participants from historically Black colleges and universities and groups that focus on issues specific to SGM people of color, our sample was mostly White. In retrospect, we recognize that this may at least partially be due to the study's focus on SGM people and public perception of the law as being motivated primarily by sexual prejudice and cisgenderism (Plazas, 2016). Accordingly, our findings reflect how this group composed mostly of White people perceive the law, and even these White people thought the law was racist. Future studies should partner with racial justice organizations, including organizations that focus on immigration issues germane to religious minorities, to specifically recruit participants of color to discuss how they might perceive this law or others like it. Our participants conceptualized the

law as multidimensionally discriminatory. In terms of intersectionality theory (Cole, 2009; Crenshaw, 1991), they saw the law as a structural form of oppression that bisects multiple axes of social inequality (Moradi & Grzanka, 2017). A sample more reflective of the racial diversity of Tennessee or which over-represents its most vulnerable populations would surely offer more insight into how the law functions in the lives of people who may be affected by it. Though we did not observe differences among our sexual minority and gender minority respondents, that does not meant gender minorities experience conscience clauses identically to sexual minorities (Hughto et al., 2015) or that there is not within-group variation in responses among trans and non-binary people (Lefevor et al., 2019). Furthermore, targeted inquiry into the intersectional dimensions of the law could further qualitatively illuminate processes of structural stigma (Hatzenbuehler, 2016) and psychological mediation (Hatzenbuehler, 2009).

We did not member check for accuracy, but that decision is consistent with our methodology and our commitment to represent our participants' experiences without critique of their perspectives and with less interpretation than might be involved in theory testing (Burawoy, 1996) or generation (Fassinger, 2005). Other methods might encourage community collaboration to focus on developing skills to empower citizens to challenge the law, or to promote more effective advocacy skills among mental health care providers. This research represents a first step in representing SGM individuals' perceptions of the law; future work should take more participatory action and community research frames in the interest of leveraging the tools of psychological science in the interest of social transformation. As Wise at al. (2015) noted, conscience clauses are not going away. And in a post-*Masterpiece* world in which legal justifications for denying services may be proliferating rather than retreating (Geidner, 2019), counseling psychologists must take an active position in the fight against institutional

discrimination—especially in mental health care. Though the Tennessee law currently does not apply to all mental health care providers, it does potentially affect anyone seeking care. If our data tell us anything, it is that members of the public perceive conscience clauses as weapons to hurt them. If we appear ambivalent, then they may ultimately perceive us the same way.

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Table 1

Participant Demographics ($N = 20$)

Name	Attended Therapy	Place of Residence	Age	Gender Identity	Sexual Orientation	Racial/Ethnic Identity	Religious Identity	Experienced Discrimination in M.H. Services
Alex	Yes	East Tennessee	35	Gender Queer	Queer	European American	Practitioner of Witchcraft	Yes
Andy	Yes	East Tennessee	31	Man	Gay	Hispanic	Christian	Yes
Abby	No	West Tennessee	33	Cisgender Woman	Bisexual	White	Does Not say	No
Brittany	Yes	West Tennessee	41	Cisgender Woman	Gay	White, not Hispanic	Protestant	Possibly, participant was unsure.
Charles	Yes	Middle Tennessee	49	Man	Gay	White	Non-Denominational Christian	No
Darling	Yes	Middle Tennessee	18	Gender Fluid	Androsexual (attracted to men)	White	Spiritual, but raised Catholic	Yes
Emma	Yes	Middle Tennessee	34	Woman	Bisexual	Caucasian	Pagan, specifically Wiccan	Yes
Jessica	Yes	West Tennessee	38	Transgender Woman	Did not share	White	Currently Spiritual, but raised Catholic	No
Joshua	Yes	Middle Tennessee	37	Man	Bisexual	Jewish, Caucasian	Jewish Conservative	No
Jennifer	Did not disclose	East Tennessee	32	Cisgender Woman	Bisexual	White	Atheist	No

John	Yes	East Tennessee	67	Man	Gay	White	None	No
Julie	Yes	East Tennessee	31	Woman	Bisexual	Caucasian	Agnostic	Yes
Jacob	Yes	Middle Tennessee	21	Cisgender Man	Asexual	Caucasian, European Dissent	Catholic	No
Kara	Yes	Middle Tennessee	33	Woman	Bisexual	Caucasian	Currently Atheist, grew up Mormon	No
Lee	Yes	East Tennessee	19	Agender, Transmasculine	Asexual, Panromantic	White	Pagan	Yes
Mary	Yes	Middle Tennessee	33	Woman	Lesbian	White, Caucasian	Christian	No
Matthew	No	East Tennessee	30	Man	Gay	White, Non-Hispanic	Confirmed Episcopalian	No
Savannah	Yes	Middle Tennessee	31	Woman	Asexual	White	Vaguely Christian-ish. Raised Southern Baptist	No
Simon	Yes	West Tennessee	34	Cisgender Man	Gay	White	Raised Episcopal and Presbyterian; currently non-relgious and Episcopal	No
Zachary	Yes	Middle Tennessee	35	Man	Gay	Hispanic, Latino	Christian, grew up Catholic	No

Note. Participants who identified as "Caucasian" or "European American" are referred to in the manuscript as "White." Similarly, we use gender terms (e.g., man, woman) rather than sex terms (male, female) in the results. We only include the term cisgender for participants who expressly used it to self-identify.

Appendix

Interview Schedule

Thank you again for agreeing to participate in this interview. Just to give you an idea of what to expect, I am going to ask you a series of demographic questions and then some questions to get to know you better. Next, I will ask you some questions about living in Tennessee and your thoughts on mental health services in the state. As the consent form details, you will not be referred to by name in any presentations or papers that we produce from this research; you are not being evaluated or judged in any way; and there are no right or wrong answers. We just want to know about your experiences living as a sexual and/or gender minority in this state. You may stop me at any time and may ask to pass on any question you don't want to answer. Please ask any questions you may have for me. With that said, do you have any questions before we begin?

1. What is your age?

2. Where are you from?
    a. If not from Tennessee, then ask: *How long have you lived in Tennessee?*

3. Where do you currently live?
    a. If they do not give you the name of a city, probe for a specific region (West, Middle, or East TN).
    b. Would you describe where you live as rural, urban, or suburban?

4. What does it mean to you to be a Tennessean?

5. How do you identify in terms of your gender and sexual orientation?

6. What is your religious affiliation?
    a. If they offer a religious affiliation, then ask: *Would you describe yourself as religious? Why or why not?*

7. What is your race or ethnic identity?

8. What are three words that your best friends would use to describe you?

9. Whether or not you have ever gone to counseling, can you tell me what you thought of or might think about when considering going to counseling or therapy? What kinds of qualities or attributes would you want your counselor to have?

10. When seeking health care, how do you know that someone is safe to talk to? What do you look for to signal that someone will not discriminate against you?

11. Have you ever been denied mental health services based on your perceived sexual or gender identity? Have you ever experienced or been the target of discrimination when seeking mental health services?

a. If yes, then say: *Tell me about that experience.*

12. Are you aware of the law in Tennessee that went into effect last year, which allows counselors to refuse to "counsel or serve a client" whose "goals, outcomes, or behaviors…conflict with the sincerely held principles of the counselor or therapist"?

    a. If yes ask, *"Can you tell me what you know about this law?"*
    b. If no, explain that the law went into effect in 2016, and states that therapists within Tennessee can refuse services to any client, so long as the therapist refers the potential client to another provider. Ask: "what is your initial reaction upon learning about this law?"

13. What do you think the consequences of the bill are–intended or otherwise?

14. In addition to LGBT+ people, who else do you think could be affected by this law?

15. Are you or anyone you know concerned about this law?
    a. If yes ask, *"What are your [their] concerns?"*

16. Have you or anyone you know been affected by it?
    a. If yes ask, *"How have they been affected?"*

17. Have you talked about the law with your close friends and family?
    a. If yes, ask, *"What are their perspectives?"*

18. Have you or any of your close friends and relatives engaged in advocacy around the law – for or against it?
    a. If yes ask, *"What did this advocacy involve?"*

19. The language of the law says that counselors may deny services and refer clients out based on their "sincerely held principles." What do you think "sincerely held principles" means?

20. From your perspective, if someone who needs help does not seek counseling, what are some of the potential consequences for that person? For society as a whole?

21. How does knowing this law exists affect your feelings about the state? How does the law align or not with your values as a Tennessean?

22. What are the mental health needs of LGBT+ Tennesseans? What can mental health care providers do to better serve the LGBT+ community in Tennessee?

23. Do you have anything else you would like to add?

24. Are you aware of **Counseling Unconditionally,** the Tennessee Equality Project's database of mental health care providers who promise not to discriminate against their clients? You can find this information at TEP online: tnep.org

I will follow up with you via email with a link to Counseling Unconditionally. Thank you so much for participating in this survey, it was great to hear your story and add it to our understanding of LGBT+ mental health in Tennessee. Would you like to see the research that is produced from these interviews? Is so, we will send you any articles as they are published.