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"Sincerely Held Principles" or Prejudice?:

The Tennessee Counseling Discrimination Law

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Abstract

In 2016, Tennessee became the first state to allow counselors and therapists in private practice to deny services to any client based on the therapist's "sincerely held principles." The law's proponents framed mental health care ethics as infringing on counselors' religious liberties; its critics denounced the bill because it apparently targeted LGBT+ individuals. This exploratory study is the first statewide assessment of LGBT+ Tennesseans' ($N = 346$) perceptions of the law and how it may affect their help-seeking attitudes and behaviors. Evidence suggests widespread awareness of the law among our respondents and deep skepticism toward mental health care. Further, most respondents view the law as cover for discrimination. We stress the need for broader research on conscience clauses and call for advocacy against these laws, which have the potential to engender widespread harm to multiple minority groups.

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

Significance of Scholarship to the Public: In 2016, Tennessee enacted a law that enables counselors and therapists in private practice to deny services to their clients based on the therapist's "sincerely held principles." This research investigates the effects of the law, which suggest that LGBT+ people in Tennessee feel targeted by this law, which they perceive to be discriminatory and motivated by religious beliefs.

“Sincerely Held Principles” or Prejudice?:

The Tennessee Counseling Discrimination Law

The post-*Obergefell v. Hodges* (2015) United States is replete with contradictions regarding lesbian, gay, bisexual, and transgender (LGBT+¹) equality. The Supreme Court's *Obergefell* decision ended the decades-long battle to achieve equal state recognition of same-sex marriage. But marriage equality catalyzed widespread efforts to erode other forms of civil rights for LGBT+ people, including a wave of proposed laws to restrict transgender individuals' use of bathrooms; enable employment discrimination on the basis of sexual orientation and gender identity; and allow business owners to deny services to LGBT+ people and others based on religious views (Adler, 2018). The Southern Poverty Law Center reports hate crimes directed at LGBT+ individuals rose to a five-year high in 2016 during the political ascension of now-President Donald J. Trump (Barrouquere, 2017). While LGBT+ people continue to achieve unprecedented levels of media representation (GLAAD, 2016), other metrics suggest negative attitudes and discrimination toward LGBT+ individuals are pervasive and perhaps intensifying (National Coalition of Anti-Violence Programs, 2018). Thus, the struggle for sexual and gender liberation persists in the wake of marriage equality (Grzanka, Mann, & Elliott, 2016).

There is increasing recognition of the need to address mental health inequities between LGBT+ people and their heterosexual and cisgender counterparts (Pérez-Stable, 2016). Decades since “homosexuality” was de-pathologized by the American Psychiatric Association, LGBT+ people still report discrimination in mental health care (Shelton &

¹ We use the acronym LGBT+ to signify inclusion of those sexual minorities and gender nonconforming individuals who do not identify as lesbian, gay, bisexual, and/or transgender (e.g., genderqueer, asexual, agender, pansexual, queer, questioning).

Delgado-Romero, 2013), and a growing body of research illustrates the impact of structural and interpersonal discrimination on the physical and mental health of LGBT+ people (Hatzenbuehler, 2016; Meyer, 2003). Examining state-level policies is one avenue for better understanding how institutional barriers affect the mental health of LGBT+ people. For example, research suggests there is a higher prevalence of negative mental health outcomes in states that recently enacted policies to restrict LGBT+ individuals' rights (Hatzenbuehler, Keyes, & Hasin, 2009; Rostosky, Riggle, Horne, & Miller, 2009). Though LGBT+ people use mental health services at disproportionately higher rates than straight and cisgender people (Cochran, Sullivan, & Mays, 2003), there are still questions about how LGBT+ people negotiate help-seeking from any licensed mental health care provider (i.e., anyone who could be considered a counselor or therapist), especially when laws and other structural dynamics may directly or indirectly impede their abilities or willingness to seek care and their expectations that care will be competent and nondiscriminatory (Meyer, Teylan, & Schwartz, 2015; Spengler & Ægisdóttir, 2015).

The state of Tennessee, colloquially referred to as the "buckle" of the U.S. Bible Belt, represents a frontline of legislation directed at eroding LGBT+ individuals' civil rights (Grzanka & Frantell, 2017). In response to one such piece of legislation, a 2016 state law that enables therapists in private practice to deny services to clients based on the provider's "sincerely held principles," we partnered with the state's largest LGBT+ advocacy organization, the Tennessee Equality Project (TEP), to study how this law might contribute to structural stigma and inequality in Tennessee. Though conservative lawmakers declined to specify the intended targets of the law, consensus among LGBT+ advocates and allied organizations was that the bill was implicitly anti-LGBT (Tamburin, 2017). This exploratory study presents the initial findings from an assessment of LGBT+

Tennesseans' perceptions of the law and their attitudes toward mental health care. Our goal was to better understand the impact this law on LGBT+ Tennesseans, providing data that may be useful in advocacy efforts to challenge the law and others like it.

Structural Stigma and Effects of Anti-LGBT+ Legislation

In April 2016, Gov. Haslam signed HB1840/SB1556, mandating that “No counselor or therapist providing counseling or therapy services shall be required to counsel or serve a client as to goals, outcomes, or behaviors that conflict with the sincerely held principles of the counselor or therapist” (Tenn. Code Ann. § 63-22-302 (2016)). The law also shields a therapist in private practice from civil lawsuits, criminal prosecution, or professional censure provided they coordinate referral to another therapist; there is an exception for clients who are suicidal or imminent danger of harming others (Locker & Meyer, 2016). The language in the original House version of the bill referred to a “sincerely held religious belief,” but was changed to the broader and potentially more inclusive “principles” (Locker & Meyer, 2016). Denounced by the American Counseling Association (ACA)², mental health professionals in Tennessee (Boehnke, 2016) and across the U.S., the bill became known as the “Counseling Discrimination Bill” because it apparently targeted LGBT+ clients (Miller, 2016). The bill’s architects in the legislature believed it was necessary to protect counselors from recent changes to the ACA’s code of ethics, which they framed as infringing on counselors’ religious liberties (Locker & Meyer, 2016). There appeared to be virtually no support for the bill among mental health professionals, even among Christian counselors

² Perhaps because the bill’s sponsors cited the ACA Ethics Code as their motivation for the law, the APA did not advocate against this bill. However, there is nothing in the law that restricts the bill’s application to counselors, as opposed to counseling psychologists. See the APA characterization of the law: <https://www.apa.org/ed/graduate/conscience-clause-advocacy.aspx>

(Duncan, 2016). Meanwhile, LGBT+ advocates made the case that the law was discrimination dressed up in the rhetoric of freedom and argued the law made an unnecessary regulatory overstep into a self-governing profession (Plazas, 2016).

This law represented one among dozens of legislative maneuvers referred to as “religious liberty” laws or “conscience clauses” (Grzanka & Frantell, 2017), though the latter term is more commonly used to refer to religious exemption bills that apply to health care professionals and others working in the public sector. Conscience clauses and similar legislative technologies function as tools for discrimination in a constellation of political and legal strategies to deny LGBT+ people’s and other minority groups’ civil rights and dignity (Adler, 2018). Research has begun to demonstrate the effects of these laws and anti-LGBT+ ballot initiatives on the mental health and well-being of LGBT+ people (Hatzenbuehler et al., 2009; Raifman, Moscoe, Austin, Hatzenbuehler, & Galea, 2018) in the context of what Hatzenbuehler (2016) has called “structural stigma” and what Collins (2000) famously termed the intersectional “matrix of domination,” in which individuals who possess multiple minority statuses may be targeted simultaneously by intersecting forms of oppression (Balsam, Molina, Beadnell, Simoni, & Walters, 2011; Grzanka & Miles, 2016; Moradi, DeBlaere, & Huang, 2010). In the context of the present study, LGBT+ Tennesseans may be experiencing structural harm at the intersection of race, religion, gender, sexual orientation, geography (i.e., rural versus urban), and social class, among other salient dimensions.

Much of the research on anti-LGBT+ legislation and political advocacy has taken a minority stress framework approach (Meyer, 2003). Echoing Bronfenbrenner’s (1979) ecological model, the minority stress model emphasizes the role structural conditions (e.g., discrimination, the denial of rights) play related to negative health outcomes.

According to Bostwick, Boyd, Hughes, West, & McCabe (2014), minority stress for LGB people is exacerbated when accounting for other marginalized identities. Hatzenbuehler's (2009) closely related psychological mediation framework further elaborates these structural dynamics by positing sexual minority stigma creates elevations in maladaptive emotional, interpersonal, and cognitive processes that, in turn, mediate the relationship between stigma and mental health problems. In general, sexual minorities in areas with higher levels of "structural stigma" (i.e., antigay prejudice) have shorter life expectancies than those who live in communities with lower levels of structural stigma (Hatzenbuehler, 2016). Further, demographic variables that denote social positioning (e.g., race, geographic region) relative to power structures (i.e., structural stigma) function as moderators, according to Hatzenbuehler (2009, 2016). The psychological mediation framework conceptually informs our work inasmuch as we would not expect all LGBT+ people in Tennessee to respond to perceived legislative discrimination in uniform ways. For example, the intersectional research on conflict in allegiances suggests those for whom sexual orientation identity is most salient and positive might perceive the law as more threatening than those for whom sexuality is less salient; on the other hand, LGBT+ people of color could perceive the law as targeting them from multiple directions (Sarno & Mohr, 2016; Sarno, Mohr, Jackson, & Fassinger, 2015). Those living in rural areas may be more affected by the law, because accessing culturally competent rural mental health care can be particularly difficult; on the other hand, LGBT+ people in urban and suburban enclaves with visible social support from other LGBT+ people and organizations may be less affected by the law (Willging, Salvador, & Kano, 2006). Especially pertinent to the present study, Hatzenbuehler (2009) stressed that, in addition to structural interventions (e.g., advocacy, media representation, public policy),

“individual-level clinical interventions that address mental health morbidity among individuals currently suffering from stigma-related stressors are also needed,” which underscores the need for competent and affirmative therapy for LGBT+ individuals (p. 709).

Empirical research has shown the impacts that both pro- and anti-LGBT+ legislation can have on LGBT+ people’s mental health. Perceived discrimination, stigma consciousness, diagnoses (of psychopathology), and depressive symptoms have been found to decrease in the context of pro-LGBT+ legislation, particularly among members of multiply marginalized groups (Everett, Hatzenbuehler, & Hughes, 2016; Hatzenbuehler et al., 2012). Riggle, Wickham, Rostosky, Rothblum, and Balsam (2016) found same-sex couples living in states that recognized civil marriage reported higher levels of LGB identity centrality and lower levels of self-concealment (e.g., closeting in the workplace) than same-sex couples in states where civil marriage was banned. Similarly, Tatum (2017) found that sexual minorities living in states where same-sex marriage was banned (prior to 2015) experienced higher levels of internalized homonegativity and worse mental health outcomes when compared to sexual minorities living in states where same-sex marriage was legal *and* all heterosexuals—even when controlling for state-level political climate.

The effects of anti-LGBT+ legislation and political campaigns are similarly well documented. Hatzenbuehler and colleagues (2009) found mental health outcomes are worse for LGB individuals in states with no legal protections (e.g., hate crimes laws, anti-discrimination regulations) compared to LGB people in states with protections and all straight people. Similarly, in states with same-sex marriage bans, researchers observed significant increases in mood disorders, alcohol abuse, generalized anxiety, and

psychiatric comorbidity (Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010). However, Maisel and Fingerhut (2011) reported that, before the vote to ban same-sex marriage in California, LGBT+ participants reported negative, ambivalent, and even positive experiences. They found legislation targeting LGBT+ people may have the unintended consequence of bringing sexual minorities and their allies together while promoting group-based resilience, in addition to negative health consequences (e.g., exposure to negative campaign messages). Gonzalez, Ramirez, and Galupo (2018) found minority stress was elevated after the 2016 election among a sample of LGBT+ individuals. They observed negative post-election outcomes including heightened levels of sexual orientation rumination, daily experiences of harassment/discrimination, and symptoms of depression and anxiety. In states where LGBT+ individuals experience structural stigma and concomitant mental health problems that could be lessened by competent and affirmative psychotherapy and medical care, LGBT+ individuals may encounter blatant discrimination and care refusal. For example, transgender individuals in Tennessee reported the 3rd highest odds (out of 50 states plus Washington, D.C.) of care refusal (Hughto, Murchison, Clark, Pachankis, & Reisner, 2016). Tennessee currently offers virtually no legal protections for transgender individuals.

Notably, efforts to restrict LGBT+ rights and promote stigma and discrimination should be viewed from an intersectional perspective (Bowleg, 2013). In Tennessee, the initial sponsors of the Counseling Discrimination Bill also support restricting abortion access (Boucher, 2015; Pody, n.d.), ending social welfare programs (Pody, n.d.), and other discriminatory policies toward racial and ethnic minorities and immigrants in Tennessee (Pody, n.d.). While LGBT+ individuals perceived the law as discriminatory (Tamburin, 2017), its scope is potentially wide-reaching and could affect members of

other marginalized groups (Plazas, 2016). An intersectional approach exposes how discrimination toward LGBT+ people cuts across multiple dimensions of identity (e.g., queer people of color, rural LGBT+ people, poor and working-class LGBT+ people) and may affect members of other dominant groups in unexpected ways (e.g., rural, Christian, heterosexual couples seeking counseling). In the present study, rather than focus solely on multiple identities and within-group differences, we: (a) foreground the structural, legal dimensions of oppression (Moradi & Grzanka, 2017), which produce vulnerability to institutional harm for groups situated at the intersections of systemic inequalities (e.g., racism, heterosexism, cissexism), and (b) conceptualize research as a tool for social transformation, rather than mere empirical description or explanation (Shin et al., 2017). We take an aspirational intersectional, “transformative” approach (Shin et al., 2017) to the present study, because we designed our research both to reflect best practices in empirical psychology *and* to contribute to activist efforts in Tennessee to document the law’s effects.

Conscience clauses that enable (i.e., legalize) discrimination may enhance stigma and impact LGBT+ people’s willingness to seek treatment, particularly because LGBT+ people already report microaggressions and other forms of subtle discrimination in mental health care (Shelton & Delgado-Romero, 2011). The APA Board of Educational Affairs (BEA) Virtual Working Group on Restrictions Affecting Diversity Training in Graduate Education created a “pedagogical statement” on conscience clauses in training as a result of recent legal and legislative actions: “Training programs are accountable for ensuring that trainees exhibit the ability to work effectively with clients/patients whose group membership, demographic characteristics, or worldviews create conflict with their own” (BEA, 2015; p. 269). Although the BEA has focused attention on conscience clause

issues in education and training in psychology (Campbell & Kim, 2015; Curry, 2015; Wise et al., 2015), less attention has been paid to conscience clauses outside of training. To our knowledge, no research has examined the impact of conscience clauses allowing professionals to deny services based on their beliefs.

Accordingly, our exploratory research sought (a) to assess knowledge and perceptions of the so-called “Counseling Discrimination Law,” the first of its kind to be signed into law, and (b) to harness the tools of psychological science to collaborate in the promotion of social justice for members of an acutely marginalized population in Tennessee. Our foremost goal was to document any potential harm the law has already caused, particularly inasmuch as these harms may inhibit help-seeking and constitute evidence to support legal contestation of discriminatory legislation. The literature on LGBT+ structural stigma and help-seeking informed our selection of variables, including assessments of perceptions of mental health care, help-seeking behaviors, LGBT+ group identity, and other potentially salient mental health outcomes, including psychological distress and self-concealment. This survey is one part of a larger yet-unpublished study modeling LGBT+ individuals’ help-seeking behavior.

Research Question (RQ) 1: Is awareness of the law related to attitudes toward psychotherapy, willingness to seek psychotherapy, ability to trust a counselor, psychological distress, and self-concealment; and does LGBT group identity affect any of these associations?

RQ2: Do demographic and geographic differences affect perceptions of the law and mental health care?

RQ3: How do LGBT+ individuals in Tennessee perceive mental health care services/service-providers?

RQ4: How do LGBT+ Tennesseans define the law’s language of “sincerely held principles”?

Method

Participants

Of the 495 individuals who opened a hyperlink to the study, we excluded 149 because they either did not respond to any item; only completed demographics; did not correctly complete the validity check (i.e., “Select 3 for this question”); did not complete the validity check; did not complete entire scales; or identified as exclusively heterosexual and cisgender (see Table 1 for demographics).

Measures

Psychological help-seeking attitudes and intentions. The 18-item Beliefs About Psychological Services (BAPS) scale (Ægisdóttir & Gerstein, 2009) measures psychological help-seeking attitudes and intentions. Items are scored using a 6-point Likert-type scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*), with higher scores reflecting more positive help-seeking attitudes and intentions. The Intent subscale (e.g., “I would be willing to confide my intimate concerns to a counselor”) reflects an individual’s willingness or intent to seek psychological services. The Stigma Tolerance subscale (e.g., “I would feel uneasy going to a counselor because of what some people might think”) measures a person’s beliefs about stigma associated with seeking mental health services. The Expertness subscale (e.g., “Counselors provide valuable advice because of their knowledge about human behavior”) reflects an individual’s perceptions of the merits of counseling. For this study, the scores for Stigma Tolerance and Expertness were combined to reflect a composite measure of attitudes toward seeking psychological help and Intent remained a standalone subscale (cf. Spengler & Ægisdóttir,

2015). The wording of the original scale was switched from seeking help from a “psychologist” to a “counselor” to be more generalizable to the field of mental health counseling. Ægisdóttir, O’Heron, Hartong, Haynes, & Linville (2011) found this alternative wording did not affect reliability or validity. Ægisdóttir and Gerstein (2009) established concurrent validity by illustrating that the BAPS was comparable to other measures of attitudes toward psychological help (e.g., Fischer & Turner, 1970) and minimally related to measures of social desirability. Ægisdóttir and Gerstein (2009) reported adequate internal consistency reliability in three studies, with Cronbach’s α ranging from .81 to .90 for Intent; .59 to .81 for Stigma Tolerance; and .72 to .78 for Expertness; alphas for the present study were .85 for Intent, .84 for Attitudes.

LGBT+ group identity. The Lesbian, Gay, and Bisexual Group Identity Measure (LGBIM; Sarno & Mohr, 2016) assesses a participant’s self-concept related to, and emotional significance of, their LGBT+ identity (e.g., “I feel a strong attachment towards the LGBT+ community”). Items on the 10-item scale are rated on a 6-point Likert-type scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). Concurrent validity was established by illustrating the LGBIM was comparable to life satisfaction, self-esteem, and outness in everyday life. Higher scores reflect more salient, positive LGBT+ group identity. In this study, we changed “LGB” to “LGBT+” in each item to better reflect the communities in our sample. Sarno and Mohr reported strong internal consistency ($\alpha = .91$); Cronbach’s α for the present study was .87.

Psychological distress. The 10-item Kessler Psychological Distress Scale (KPDS; Kessler et al., 2002) was used to measure psychological distress. Participants are asked how much they endorsed psychopathological symptoms (e.g., depressed, nervous, worthless) in the past 30 days. Items (e.g., “During the past 30 days, about how often did

you feel so sad that nothing could cheer you up?") are scored on a 5-point Likert-type scale ranging from 1 (*none of the time*) to 5 (*all of the time*). Higher scores reflect higher levels of psychological distress. Furukawa, Kessler, Slade, and Andrews (2003) established concurrent validity of the KPDS with the General Health Questionnaire (Goldberg & Hillier, 1979) and predictive validity with DSM-IV mood and anxiety disorders. Kessler and colleagues (2002) reported good internal consistency in four studies ($\alpha = .89$ to $.93$); likewise, we observed Cronbach's $\alpha = .93$.

Self-concealment. The 10-item Self-Concealment Scale (SCS; Larson & Chastain, 1990) assess active concealment of personal information from others that is perceived as negative or distressing (e.g., "I have negative thoughts about myself that I never share with anyone"). Items are scored on a 5-point Likert-type scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*), with higher scores indicating greater self-concealment. Larson and Chastain established construct validity through significant correlations with social support, distress, and secrecy. Like Larson and Chastain's initial report ($\alpha = .83$), we observed strong internal consistency ($\alpha = .91$).

Demographic questionnaire. We asked participants to report their age, race and/or ethnicity, gender identity, sexual orientation, social class (as assessed by the MacArthur Subjective Social Status scale; Adler, Epel, Castellazzo, & Ickovics, 2000), current and past geographic description (i.e., rural, suburban, urban), prior counseling experience, and rating of prior counseling experience.

Awareness and understanding of the Tennessee law. We also developed five items, one of which was open-ended. Three were anchored on a 1 (*not at all*) to 7 (*very much*) Likert-type scale, and included: "If you knew that a counselor could legally deny you services based on that counselor's sincerely held principles, would that affect your

willingness to seek counseling?”, “If you knew that a counselor could legally deny you services based on that counselor’s sincerely held principles, would that affect your ability to trust a counselor?” and “If you knew that a counselor could legally deny you services based on that counselor’s sincerely held principles, that would affect my well-being.” We asked participants to respond “yes,” “no,” or “unsure” to the following item: “Are you aware that in the state of Tennessee, counselors can legally deny you services based on their ‘sincerely held principles’?” Finally, we asked: “How would you define ‘sincerely held principles’?”. because of the contentious debate about the law’s original language about “religious beliefs.”

Procedure

Participants were recruited online through LGBT+ social groups, community centers, campus organizations in Tennessee, and the TEP. We used a snowball sampling approach (i.e., asking participants to forward recruitment emails), which is typical in research with difficult-to-reach populations (e.g., Greene & Britton, 2012). The recruitment letter invited participation in an online study on beliefs about psychological services and perceived barriers to help-seeking of individuals who identify as LGBT+. Previous research suggests an altruistic incentive results in higher participation rates than personal cash payments (Robertson & Bellenger, 1978). Therefore, participants were informed their participation would result in a small (\$1) donation to TEP.

Analytic Plan

Our preliminary analysis in SPSS 25 showed less than 1% missing data for any individual item. Per best practices, expectation maximization was used to impute missing variables (Schlomer, Bauman, & Card, 2010). Next, we examined descriptive statistics for key variables, including items developed specifically to assess awareness of

Tennessee's law. We then examined differences in responses to these items based on dimensions of social difference, and correlations among all continuous variables. We then conducted post-hoc ANOVAs to explore potential interactions. We used basic content analysis (Weber, 1990) to determine word frequencies for the open-ended item.

Results

All variables were normally distributed (skewness and kurtosis $> \pm 1.5$) except LGBT+ group identity [skewness = -1.106 ($SE = .131$) and kurtosis = 1.956 ($SE = .261$)]. Participants reported legislation allowing counselors to deny services based on their sincerely held principles would affect their willingness to seek mental health counseling ($M = 5.73$; $SD = 1.81$), ability to trust a counselor ($M = 6.00$; $SD = 1.58$), and overall well-being ($M = 5.29$; $SD = 1.82$), with higher scores on a 1-to-7 scale indicating such legislation would "very much" affect respondents' help-seeking behavior and well-being. Additionally, most participants (76.6%; $n = 265$) reported they were aware of the Tennessee law; fewer were not aware (15.0%, $n = 52$) or not sure (7.8%, $n = 27$).

We observed no significant differences in the four original counseling discrimination-related items based on geographic location, prior counseling, prior counseling rating, race and/or ethnicity, gender, sexual orientation, and self-reported SES. Age was significantly negatively correlated with the law's impact on their willingness to seek mental health counseling ($r = -.21$, $p = .000$, $n = 343$), willingness to trust a counselor ($r = -.137$, $p = .011$, $n = 342$), and overall well-being ($r = -.155$, $p = .004$, $n = 341$), whereby younger participants reported a larger effect than older participants, though the effects were weak (Cohen, 1992).

Participants' ratings of the effect of a counselor being able to legally deny services due to their sincerely held principles on their willingness to seek mental health

counseling, propensity to trust mental health counselors, and overall well-being were significantly associated with more negative attitudes towards mental health counseling (both in terms of counselor expertise and mental health care stigma), higher psychological distress, higher self-concealment, and lower family support (see Table 2).

To better understand the relation between LGBT+ group identity and awareness of the law, we performed post-hoc two-way ANOVAs on the other variables. For non-normal data, we used a Mann-Whitney U test, which indicated LGBT+ group identity scores for individuals aware of the “Counseling Discrimination Law” were significantly higher than the LGBT+ group identity scores for those unaware of the law. Due to the non-normal distribution of LGBT+ group identity, participants were split at the sample median for the mean of the scale (5.2), constituting two groups representing low-to-moderate and highest scores on LGBT+ group identity, respectively. Although not directly related to the research question, there were significant main effects of LGBT+ group identity on attitudes toward counseling, and intentions to seek counseling such that individuals high in LGBT+ group identity had more positive attitudes toward counseling and intentions to seek counseling than individuals relatively lower in LGBT+ group identity.

Post hoc two-way ANOVA indicated a significant interaction between the effects of LGBT+ group identity and awareness of the law on self-concealment, $F(1, 340) = 5.269, p = .022$ (see Figure 1). For those highest in LGBT+ group identity, simple main effect analysis showed individuals aware of the law reported significantly more self-concealment than individuals not aware of the law, $F(1, 340) = 5.428, p = .020$. For individuals lower in LGBT+ group identity, awareness of the law had no effect on self-concealment, $F(1, 340) = .541, p = .462$. For individuals aware of the law, simple main

effect analysis showed those with lower LGBT+ group identity had significantly higher levels of self-concealment than those with higher LGBT+ group identity, ($F(1, 340) = 7.010, p = .008$). For individuals not aware of the law, those with low LGBT+ group identity had significantly higher levels of self-concealment than those with higher LGBT+ group identity, ($F(1, 340) = 15.544, p < .001$).

Post hoc two-way ANOVA indicated a significant interaction between LGBT+ group identity and awareness of the law on psychological distress, $F(1, 340) = 4.953, p = .027$ (see Figure 2). For individuals unaware of the law, simple main effect analysis indicated those highest in LGBT+ group identity had significantly lower levels of psychological distress than those lower in LGBT+ group identity, $F(1, 340) = 8.881, p = .003$. For individuals aware of the law, LGBT+ group identity had no effect on psychological distress, $F(1, 340) = .863, p = .354$. For individuals with high LGBT+ group identity, those aware of the law did not report significantly different levels of psychological distress than those unaware of the law, $F(1, 340) = 2.752, p = .059$. For individuals with low LGBT+ group identity, awareness of the law did not have an impact on psychological distress, $F(1, 340) = 1.413, p = .235$.

Open-ended question. Responses were imported into Microsoft Excel for basic content analysis (Weber, 1990). Most participants ($n = 329$) offered some kind of response to the question “How would you define ‘sincerely held principles’?” Responses were not grouped or coded as in thematic analysis or grounded theory; our objective was to calculate descriptive statistics regarding the frequency of common responses (Weber, 1990). Responses ranged from a single word (i.e., “prejudice”) to two full sentences or 63 words. Over 50% of the responses ($n = 167$) made reference to the words “belief” or “believe,” which was similar to the original language of the bill; “belief” was the most

commonly used noun. Similarly, 178 respondents (54.10%) made reference to religion, religious, or some word derived from the consecutive letters “relig.” Indeed, the most common response was simply “religious beliefs” ($n = 43$). The responses emphasized discrimination, religion, morals, and prejudice. Though respondents referenced homophobia ($n = 5$), “gay” ($n = 1$), and “LGBT” ($n = 9$), responses generally stressed religion and broad discrimination (see Table 3).

Discussion

Our findings reveal two themes that offer insight into LGBT+ individuals’ perceptions of Tennessee’s so-called “Counseling Discrimination Law.” First, our data suggest widespread awareness of the law—at least among our respondents—and significant associations between potential conscience clause-type legislation and: (1) perceptions of mental health care, (2) willingness to seek services, and (3) psychological distress. Second, the majority of our respondents perceive “sincerely held principles” to be a kind of codeword for “beliefs” or religion, which reflects the original language of the law. While lawmakers in Tennessee changed the final language of the bill, our respondents perceive the law to reflect its original form. This is an especially important finding given that lawmakers’ modification of the bill’s initial language was viewed as political cover for a law that was otherwise potentially unconstitutional (Plazas, 2016).

On the one hand, our data are hardly surprising given what psychologists have documented about LGBT+ individuals experiences in mental health care and help-seeking behaviors more broadly (Shelton & Delgado-Romero, 2013). Therapists know how important affirmative care is for all those seeking help (Grzanka & Miles, 2016), and ethics codes and professional guidelines reflect this (Bieschke & Mintz, 2012). As the first plaintiff who attempted to challenge it in court asserted (Tamburin, 2017), this law

undermines the trust necessary for a positive working alliance. Given that LGBT+ individuals already face numerous, well-documented barriers to help-seeking (Shelton & Delgado-Romero, 2013), this law may exacerbate an already dire mental health care issue. Following Hatzenbuehler's (2016) call for research on structural stigma, we examined how demographic and geographic differences might inform perceptions of the law and mental health care. With one exception (age), awareness of and perceptions of the law, as well as perceptions of mental health care more broadly, did not differ in our sample in terms of other dimensions of identity, though this does not mean that our participants necessarily experience anti-LGBT+ structural stigma in the same ways. We also did not use any expressly intersectional measures in our survey (Sarno et al., 2015). Indeed, future qualitative research may better capture subtle intersectional dynamics in this population.

On the other hand, our data reveal dynamics that may illuminate LGBT+ help-seeking practices in hostile environments (i.e., structural stigma) and potentially contribute to legal challenges to the law, which is one goal of transformative scholarship (Shin et al., 2017). Though LGBT+ group identity was generally high in our sample, those who were highest in LGBT+ group identity and aware of the law were more likely to engage in practices of self-concealment than those unaware of the law. However, LGBT+ group identity did not distinguish observed levels of self-reported psychological distress among our respondents who were aware of the law, suggesting that LGBT+ group identity may not fully buffer the effects of such discriminatory legislation.

Among those aware of the law, those lower in LGBT+ group identity were more likely to self-conceal than those higher in LGBT+ group identity. Meanwhile, among those unaware of the law, we observed differences in psychological distress consistent

with the psychological mediation framework (Hatzenbuehler, 2009), such that those higher in LGBT+ identity reported lower levels of psychological distress. In Hatzenbuehler's (2009) terms, LGBT+ group identity could be thought of as a moderator in the mediated relationship between structural stigma and distress, though testing a mediated moderation hypothesis was beyond the scope of our study. Nevertheless, our findings suggest those with lower LGBT+ group identity are more likely to self-conceal than their higher LGBT+ group identity counterparts, but awareness of the law minimizes the differences in distress between those with different levels of LGBT+ identity. Though we cannot determine causation from these data, future research should explore how conscience clause legislation may directly affect mental health, and how LGBT+ identity may indirectly contribute to how people respond to such structural dynamics (Hatzenbuehler, 2016).

Notably, our respondents appear to possess a keen awareness of the law's original intent—to enable religiously motivated denial of services (Miller, 2016). The emphasis on “beliefs” and “religion” in our opened-ended question about the meaning of “sincerely held principles” suggests our respondents perceive the law as directly (as opposed to subtly) about religion. While the highest levels of the U.S. legal system continue to work through challenges to free speech and religious freedoms (Adler, 2018), mental (and other) health care providers should be invested our clients' perception of our fields and legislative/judicial developments that may engender discrimination in our fields. After Gov. Haslam signed the bill, the TEP inaugurated the “Counseling Unconditionally” project (TEP, n.d.), which lists mental health service providers who have pledged they do not discriminate against LGBT+ clients and “will not use our own sincerely held

principles as a reason to turn clients away.” This is one exemplar of an affirmative reaction to structural stigma.

Our sample is limited by self-selection bias and is not generalizable to all LGBT+-identified Tennesseans, though it was geographically diverse and represented all regions of the state. While our sample is diverse by some metrics, our majority-White sample does not reflect the racial-ethnic diversity of Tennessee, and so our ability to effectively capture some intersectional dynamics is limited. However, responses to the open-ended items suggest participants do not view the law strictly in identitarian terms (Grzanka & Miles, 2016): its vague language led respondents to characterize “sincerely held principles” as broadly discriminatory, rather than exclusively heterosexist or transphobic. Also, the limits of quantification necessarily reduced complex help-seeking dynamics in our dataset; accordingly, our next step involved contacting respondents and interviewing them about the law and their help-seeking experiences to expose nuance obscured by our statistical analyses (DeVore, Frantell, Grzanka, Miles, & Spengler, manuscript in preparation). We are also using other data from this project to explore a model of LGBT+ help-seeking that may inform future research on mental health services in the context of structural stigma.

Implications for Practice, Advocacy, Education/Training, and Research

Consonant with our intersectional approach and the explicit social justice orientation of our work, our community partner (TEP) was involved in all stages of this research. Funding from [masked for review] enabled us to make a \$1,000 donation to the organization, which we used to incentivize participation and support local efforts to promote LGBT+ equality in Tennessee. Furthermore, the intersectional perspective that informs our work demands an eye toward social transformation (Moradi & Grzanka,

2017). Although our data do not demonstrate harm in of themselves, and so may not constitute standing in court, we hope these data and other research on this law may facilitate its repeal or juridical attempts to challenge it. This work might also model avenues through which counseling psychologists in-training and practicing clinicians might address structural stigma in their clinical and advocacy work by exploring with clients how environmental and political issues are informing attitudes toward and barriers to mental health care. The greatest exigency for this work and its implications are interference in our profession from elected officials, which undermines our ability to provide affirmative and ethical care to some of the most vulnerable members of our communities. Although Tennessee holds the dubious honor of being the first state with such a law, others will likely follow without proactive advocacy on behalf of helping professionals. Before these laws become commonplace throughout the U.S., counseling psychologists should incorporate training about conscience clauses into graduate and continuing education so that we are well prepared to explain to elected officials and the public why, contrary to their stated aims, these laws produce harm.

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Table 1
Demographics

<u>Characteristic</u>	<u><i>n</i></u>	<u>%</u>	<u><i>M (SD)</i></u>
Age	346		34.57 (12.97)
Gender			
Woman	174	49.4	
Man	136	38.6	
Transgender	30	8.5	
Other	27	7.7	
Sexual Orientation			
Straight/Heterosexual	8	2.3	
Gay or Lesbian	197	56.0	
Bisexual	91	25.9	
Queer	72	20.5	
Other	32	9.1	
Race and/or ethnicity			
Asian/Asian			
American/Pacific Islander	4	1.1	
Native American/American Indian	2	0.6	
Black/African American	14	4.0	
Latina/o or Hispanic (non-White)	7	2.0	
White/European American	322	91.5	
Other	3	0.9	
Subjective Social Status (lowest to highest)			5.22 (1.79)
1	3	0.9	
2	18	5.2	
3	44	12.7	
4	64	18.5	
5	65	18.8	
6	52	15.0	
7	67	19.4	
8	27	7.8	
9	4	1.2	
10	2	0.6	
Zip Code (Growing Up)			
Urban	36	10.4	
Suburban	173	50.0	
Rural	129	37.3	
Other	8	2.3	

Zip Code (Current)			
	Urban	128	37.0
	Suburban	159	46.0
	Rural	50	14.5
	Other	9	2.6
Previous Counseling			
	Yes	281	81.2
	No	65	18.8
Rating of Previous Counseling: 1 (Very Negative)- 7 (Very Positive)			4.90 (1.62)

Table 2

Correlation Matrix and Awareness Group Comparisons

	Hypothetical “CD Law” Willingness Impact	Hypothetical “CD Law” Trust Impact	Hypothetical “CD Law” Well-Being Impact	“CD Law” Awareness ***
BAPS Attitudes	-.164**	-.161**	-.160**	$t(342) = .438$
BAPS Intent	-.117*	-.119*	-.029	$t(342) = .853$
Psychological Distress	.228**	.244**	.313**	$t(342) = -.163$
Self- Concealment	.178**	.159**	.265**	$t(342) = .125$
LGBT+ Group Identity	.061	.034	.084	$U = 10301.00$ **

Note. ** = correlation significant at the .01 level (2-tailed), * = correlation significant at the .05 level (2-tailed); *** Mann-Whitney U performed due to non-normal data distribution of LGBT+ Group Identity. BAPS Attitudes = Beliefs About Psychological Services Expertness and Stigma Tolerance subscales; BAPS Intent = Beliefs About Psychological Services Intention subscale; PD = Kessler Psychological Distress Scale; Self-Concealment = Self-Concealment Scale; LGBT+ Group Identity = adjusted Lesbian, Gay, and Bisexual Group Identity Measure; Tennessee Law Awareness answers of “no” and “not sure” collapsed into one group.

Table 3

Responses to the question "How would you define 'sincerely held principles'?"

"Sounds like discrimination."	"The right to be a bigot."
"I'm secretly a hateful homophobe and/or transphobe who sticks their nose so high up birds shit on it."	"Religious or moral beliefs that ought not interfere with providing unbiased service and work practices"
"Being heterosexual"	"Religious doctrine, mostly."
"It's vague enough to define it in any way. It could be political, religious, or a completely uninformed opinion."	"I can't. It's too vague. Mental health counselors have code of ethic that should be the sole guiding principles"
"Ughh..maybe religious or moral convictions. However, it seems that it is open enough for anything as long as you make a good enough argument. I dont like the wording. It feels too open ended, like if I just feel like it."	"Well HB 1840 originally used the language of "sincerely held religious principles" I believe, so I guess the intent of the bill was to protect the freedom of religion, but really we all know that it is to codify religious-based discrimination."
"I'm not sure how to define that. I think it would mean different things to everyone. In this context, it seems like it means conservative Christian religious belief."	"A core belief. However, in this sense it means if one finds the homosexuality/LGBTQ lifestyle offensive/damning, one can refuse to treat that group of people."
"Principles that could potentially deny a person's humanity but are justified by religion"	"Principles that are backed by some recognized institution, largely religious."
"Pseudo-religious bigotry that violates the ethics of being a counseling or medical professional"	"Beliefs...I don't think anybody can approve the "sincerely" part. I basically think this is a cop-out for counselors who don't want to see clients because they don't have the same values and beliefs."

Note. n = 329.

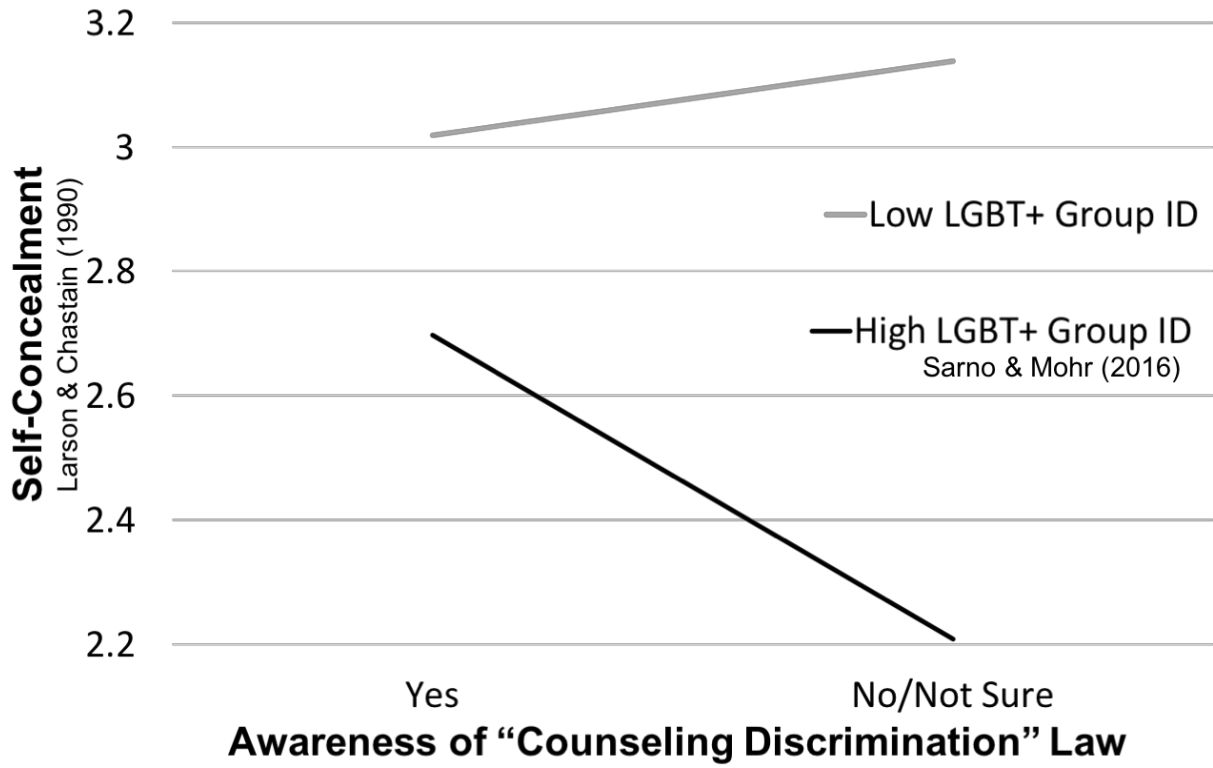


Figure 1. Self-Concealment two-way ANOVA.

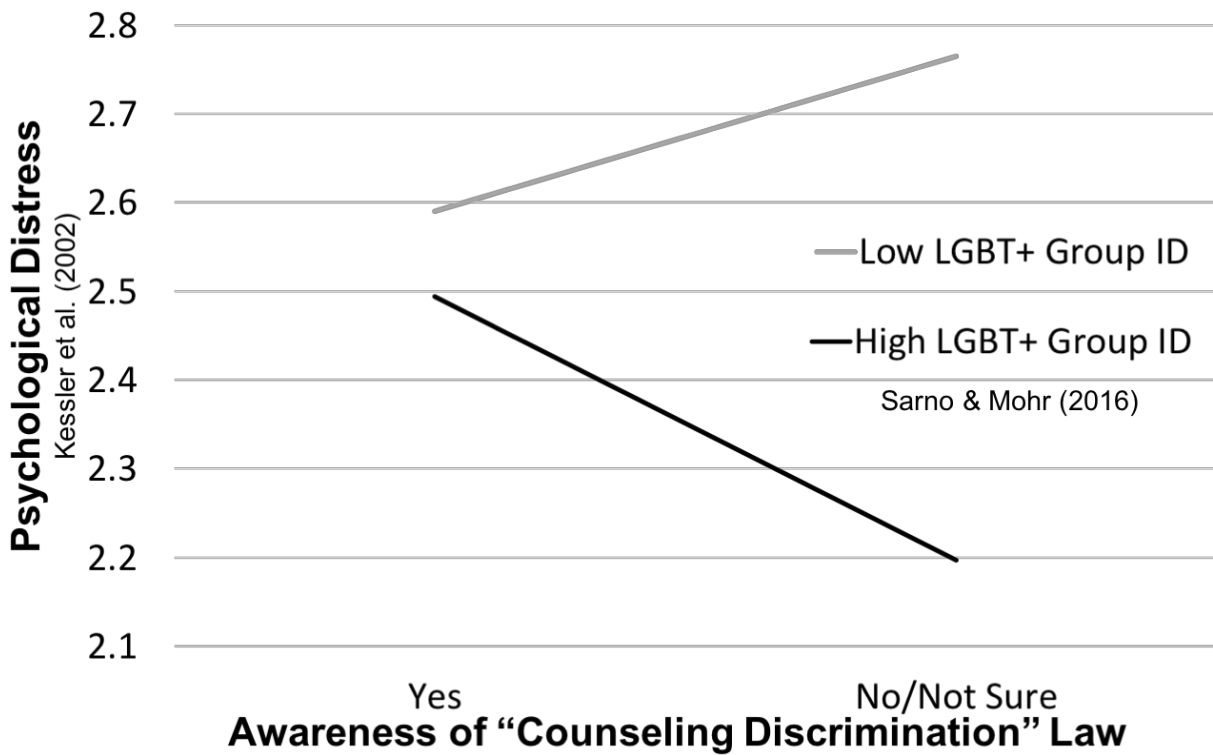


Figure 1. Psychological Distress two-way ANOVA.