Political Ideologies, Political Party Affiliation, and Treatment Decisions of Clinical Mental Health Counselors

by

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Dedication

This dissertation is dedicated to my husband, Valentino Travieso, who expresses his love through affection, effort, and support. I am grateful for his patience over the last several years as I juggled my private practice, volunteer responsibilities, and doctoral studies while he held our home together. I would like to thank my friends and family members, including my parents, brothers, sisters, nieces, and nephews, all of whom encouraged me while I was less available these last several years. I would also like to thank my committee members. Dr. Tony Tan encouraged me when I lacked confidence to publish and connected me with so many academic opportunities. Dr. Robert Dedrick's patient instruction helped me to make sense of data analysis when I didn't think I could. Dr. Cynthia Topdemir's guidance helped me to get "unstuck" several times in my doctoral process. Dr. Mark Pezzo stimulated and fostered my interest in social psychology so many years ago as his undergraduate student. I would also like to thank the many professors who mentored and influenced me over the years, including Dr. David Stenmark, whose passion for clinical psychology I found infectious; Dr. Herbert Exum and Dr. Edward Fletcher, Jr., who helped me get started with my dissertation; Dr. Joseph Ferrandino, who encouraged me to have an early midlife crisis; Dr. Susan Kelly, who astounded me with her clinical expertise; Dr. Tennyson Wright, who believed in me and offered me my first teaching opportunity, and all of the other faculty of the University of South Florida's Rehabilitation and Mental Health Counseling program. Finally, I'd like to thank Mac Jacobs, LMHC, LMFT and Jane Maguire, LMHC, my mentors in clinical practice as well as my dear friends.

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Abstract

Literature in the counseling profession has emphasized the importance of recognition of the potential impact of counselor bias on clinical care for decades. A large body of research has been developed on the potential for the personal, social, and religious beliefs of clinical mental health counselors (CMHCs) to impact their work with clients, but comparatively little research has been conducted on the potential impact of the political beliefs of CMHCs and their clinical practice, creating a gap in the professional literature. The present study sought to bridge the gap in CMHC literature by examining the relationship between the political ideologies, political party affiliations, perceived level of seriousness of politicized problems, and treatment decisions of CMHCs by testing the hypothesis that politically conservative CMHCs (i.e., CMHCs who self-identify as politically conservative or are registered Republicans) would (1) rate the seriousness of politicized but not non-politicized issues differently, and (2) choose different treatment interventions for politicized but not non-politicized clinical issues than other CMHCs. Survey data were collected from 168 members of the American Mental Health Counselors Association on the level of seriousness of clinical problems and the likelihood of selecting various treatment interventions for six non-politicized and five politicized clinical vignettes. Multiple regression analyses revealed that (1) conservative CMHCs rated the level of seriousness of clinical vignettes involving two politicized issues (i.e., gun storage and abortion) differently than other CMHCs; and (2) Republican CMHCs chose different treatment interventions for vignettes involving one non-politicized issue (i.e., tobacco use) and one politicized issue (gun storage) as compared to other CMHCs. Hypotheses were therefore only partially supported.

Implications for the profession of clinical mental health counseling and recommendations for additional research are discussed.

Chapter One: Introduction

Background of the Problem

Extensive research has demonstrated that mental health professionals' personal, social, and religious beliefs influence their interactions with clients (e.g., Barrett & McWhirter, 2002; Blair, 2015; Blair, Cummings, Ivan, Carson, Stanley, & Pargamant, 2014; Bloom, Gutierrez, Lambie, & Alie, 2016; Parikh, Post, & Flowers, 2011). Because beliefs in social issues and religion are likely reflected in one's political beliefs and the broader construct of one's worldview (Bilgrave & Deluty, 2002; LaMothe, 2012), it would be reasonable to argue that mental health practitioners' political beliefs should matter in their counseling practice. While research remains scarce, the importance of recognizing one's biases when working with clients has been stressed both in peer-reviewed counseling literature (e.g., Dorre & Kinnier, 2006; Pietrofesa & Schlossberg, 1970; Strohmer & Shivy, 1994) and counseling training materials (e.g., Corey, 2013; Erford, 2015; Gladding & Newsome, 2018; Murdock, 2017) for decades.

This emphasis arose in part from several historic events highlighting the influence of counselor worldview in clinical practice. For example, homosexuality was listed as a category of sexual deviation in the original *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published in 1952 (American Psychiatric Association, [APA] 1952). The conceptualization of homosexuality as a mental disorder was connected to the beliefs of many mental health professionals of the time, who believed homosexuality to be a medical defect, a moral failure, a form of developmental immaturity, or a result of behavioral conditioning (Drescher, 2015). This diagnosis remained in the second edition of the DSM, published in 1963 (APA, 1963). Ten

years later, after several notable psychiatrists argued for a viewpoint of homosexuality as a normal and natural variation affecting a minority of the population (Drescher, 2015), the Nomenclature Committee of the APA declared that unlike other conditions categorized as sexual deviation, homosexuality did not regularly cause "objective distress…[nor was] associated with generalized impairment in social effectiveness of functioning" (Stoller, et al., 1973, p. 211). Shortly thereafter, several other APA committees followed suit, and the APA Board of Trustees voted to remove homosexuality from the DSM (Drescher, 2015). However, in 1980 ego-dystonic homosexuality was included in the DSM-III as a diagnosis denoting a person with a homosexual orientation who persistently wanted to be heterosexual (APA, 1980). This new diagnosis was recognized as a political concession for opponents of the Board's decision, as well as an opportunity to continue the practice of reparative or conversion therapy aimed at changing sexual orientation (Drescher, 2015). Ego-Dystonic Homosexuality remained in the revised edition of the DSM-III, published in 1987, along with coding for homosexual subtypes of other disorders (APA, 1987). It wasn't until the fourth edition of the DSM, published in 1994, that Ego-Dystonic Homosexuality was entirely removed from the DSM as a diagnostic category. Although homosexuality is no longer a disorder in the DSM and the major professional associations in the mental health profession, reparative therapy continues to be practiced today by counselors who believe homosexuality to be pathological, and the practice remains legal in most states (Miller, 2018).

An additional example of the influence of counselor bias on clinical practice involves the refusal to provide counseling services to clients because of a clash between the beliefs of the counselor and the sexual orientation of the client. Within the past four years, the ethical codes of the American Counseling Association (ACA), the largest association in the United States

representing counselors, and the American Mental Health Counselors Association (AMHCA), the largest association exclusively representing clinical mental health counselors (CMHCs), have been revised to strengthen focus on the obligations of counselors to be mindful of the impact of their values and beliefs on their work with clients (ACA, 2014a; AMHCA, 2015; Meyers, 2014). These codes were revised in part as a reaction to legislation in some states that would permit licensed counselors to refuse or modify care provided to clients based on the religious beliefs of counselors (Meyers, 2014). The first was a 2009 case Ward v. Wilbanks, in which a graduate counseling student named Julea Ward questioned whether she should refer a student seeking counseling from her for depression related to a homosexual relationship because of a clash between her evangelical Christian beliefs and the client's orientation. Ward was referred to the university's remediation program and eventually dismissed from her counseling program at Eastern Michigan University (Burkholder, Hall, & Burkholder, 2014). The second case, Keeton v. Anderson-Wiley, involved a graduate counseling student named Jennifer Keeton, who self-identified as a conservative Christian. Keeton was referred to her university's remediation program after Keeton verbalized support for conversion therapy, indicated that she believed homosexuality to be a form of identity confusion, and announced an intention to try and help clients change their sexual orientation (DeMitchell, Hebert, & Phan, 2013). She sued her program unsuccessfully in federal court, "alleging several constitutional violations, including viewpoint discrimination, retaliation, and compelled speech, in violation of her First Amendment rights and her right to free exercise of religion" (DeMitchell, Hebert, & Phan, 2013, pp. 319-320).

Because of these two cases, the ACA revised its code of ethics to strengthen its position on the importance of counselors recognizing their biases and on the need to avoid value

imposition on clients (Meyers, 2014). The revised code asserts that counselors should be "aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors" (ACA, 2014a, p. 5) and "seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature" (ACA, 2014a, p. 5). AMHCA followed suit in 2015, revising its code to require CMHCs to be aware of their "own values, attitudes, beliefs and behaviors" (p. 6) as they relate to securing informed consent for counseling (Section I.A.1.b), counseling clients from diverse backgrounds (Sections I.A.4.d and I.C.1.m), formulating treatment plans (Section I.B.1.a), and providing professional consultation (Section I.F.1). Additionally, the code implores CMHCs to seek awareness of the values of client populations (Section I.C.1.g) and the general public (Section V). Finally, the code requires CMHCs to promote the values of the profession itself (Section IV).

Despite these revisions to ethical codes in the counseling profession, some state legislatures have passed or attempted to pass legislation affirming the rights and perceived duties of CMHCs to refuse treatment or take other potentially unsupportive actions based on clashes between the personal religious beliefs of CMHCs and presenting concerns of clients. For example, in 2018 the Ohio General Assembly introduced H.B. 658, which "would require professional counselors and teachers to 'out' transgender children and youth to their parents," (ACA, 2018). In 2016, legislation was blocked in Mississippi that would have permitted CMHCs to deny services to lesbian, gay, bisexual, transgender, and questioning (LGBTQ) clients (Green, 2016). In 2015, legislatures in Tennessee passed HB 1840 and SB 1556, allowing CMHCs to discriminate against lesbian, gay, bisexual, transgender, and questioning clients, and in 2016 a new bill was introduced that would allow Tennessee to write its own

ethical code for counselors in response to ACA's decision to move its annual conference from Nashville, Tennessee to San Francisco, California in protest of HB 1840 and SB 1556 (ACA, 2016). Conversely, several states, predominantly in the northeastern and western regions, have passed legislation enforcing the positions of the associations within the mental health professions, banning reparative or conversion therapy (i.e., Washington, Oregon, California, Nevada, Colorado, New Mexico, Hawaii, Illinois, New York, Vermont, New Hampshire, Maine, Massachusetts, Rhode Island, Connecticut, New jersey, Delaware, Maryland, District of Columbia, Colorado, and New Mexico) (Movement Advancement Projects, 2019).

Problem Statement

Only a small number of studies have examined the political beliefs and ideologies of mental health professionals, including clinical mental health counselors (CMHCs), social workers, and counseling psychologists, finding that the majority of mental health professionals identify as politically liberal and are much more likely to be members of the Democratic Party than other parties (e.g., Bilgrave & Deluty, 2002; Norton & Tan, 2019; Parikh, Post, & Flowers, 2011; Rosenwald, 2006; Stele, Bischof, & Craig, 2014). Two studies have demonstrated relationships between the political ideologies of counselors and their preferred counseling theories (i.e., Bilgrave & Deluty, 2002; Norton & Tan, 2019). However, there exists a gap in the professional literature in terms of how a counselor's political ideology relates to his or her specific treatment decisions, especially on politicized issues such as abortion, gay adoption, and gun ownership. There is only one recent study that might such light on this issue, though its participants were healthcare practitioners of an entirely different specialty area. Specifically, Hersch and Goldenberg (2016) identified a link between the political party affiliations of primary care physicians (PCPs) and their preferred treatment decisions in case vignettes related to

politicized health issues (e.g., recreational marijuana use, firearm ownership and storage in a household with small children, abortion), finding that Republican PCPs expressed more concern than Democratic PCPs for vignettes involving recreational marijuana use, and abortion, whereas Democratic PCPs expressed more concern than Republican PCPs for a vignette involving gun storage. Additionally, Republican PCPs were more likely to report that they would discuss health risks associated with marijuana use, abortion, and sex with sex workers than Democratic PCPs. While political affiliation was related to treatment decisions of PCPs, it remains unknown whether a similar pattern exists for CMHCs. To fill this gap, the present study aims to investigate this empirically.

Research Questions and Hypotheses

The present study was designed to explore four research questions:

(1) What is the relationship between CMHCs' reported political ideology (i.e., conservative as compared to all other political ideologies) and their perceived levels of seriousness of problems related to politicized issues (i.e., marijuana use, abortion, gay adoption, firearms, sex reassignment)?

(2) What is the relationship between the reported political party (i.e., Republican as compared to all other political parties) of CMHCs and their perceived levels of seriousness of problems related to politicized issues (i.e., marijuana use, abortion, gay adoption, firearms, sex reassignment)?

(3) What is the relationship between the reported political ideology (i.e., conservative as compared to all other political ideologies) of CMHCs and their treatment decisions about case examples that involve politicized issues (i.e., marijuana use, abortion, gay adoption, firearms, sex reassignment)?

(4) What is the relationship between the reported political party (i.e., Republican as compared to all other political parties) of CMHCs and their treatment decisions about case examples that involve politicized issues (i.e., marijuana use, abortion, gay adoption, firearms, sex reassignment)?

Based on findings from the only available study on PCPs and Moral Foundations Theory (MFT), it was tentatively hypothesized that there would be statistically significant differences between conservative and non-conservative counselors on the perceived level of seriousness of various clinical problems and treatment decisions.

Purpose and Significance of Study

The purpose of this study was to explore the relationship between the political ideologies, political party affiliations, and treatment decisions of clinical mental health counselors (perceived level of seriousness of clinical problems related to politically charged subject matter and selected treatment plan objectives). This purpose was significant because of the established focus in the profession on understanding the impact of counselor bias on clinical practice. Much like Duarte, Crawford, Stern, Haidt, Jussim, and Tetlock (2015) posited that the field of social psychology may benefit from political diversity due to bias in the profession, the same may be true for clinical mental health counseling.

Theoretical Framework

The study was expected to add to the body of knowledge related to MFT, a theory developed to explain and understand how and why human beings reason differently on moral, ethical, religious, and political issues (Haidt & Joseph, 2004; Haidt, 2012). MFT is the byproduct of research conducted by Jonathan Haidt and Joseph Craig on the moral matrices of various cultures in an effort to extract universal cognitive modules humans use when reasoning

morally (Haidt & Craig, 2004; Haidt, 2012). Modules are described as "little switches in the brains of all animals…[that] are switched on by patterns that were important for survival in a particular ecological niche, and when they detect that pattern, they send out a signal that (eventually) changes the animal's behavior in a way that is (usually) adaptive" (Haidt, 2012, Kindle location 2280). Essentially, human beings (1) start with innate or intuitive psychological systems referred to as moral foundations, then (2) cultures and societies build virtues, narratives, and institutions on these foundations, resulting in (3) unique moralities that co-exist across the world as well as across the political spectrum (Haidt & Craig, 2004; Haidt, 2012). Each moral foundation is theorized to have developed to prepare humans for one or more adaptive challenges and is associated with particular emotions and relevant virtues. Those moral foundations include:

1. Care/Harm: A foundation rooted in the evolutionary process of mammals with attachment systems that enable humans to feel and dislike the pain of others. The foundation was initially triggered by the suffering of one's own offspring but has generalized with time to additional triggers (e.g., pictures of babies and young children, cute animals, etc.). It is associated with virtues of caring and kindness and the emotion of compassion (Haidt, 2012).
2. Fairness/Cheating: A foundation based on the evolution process of reciprocal altruism, a term coined by Robert Thrivers in 1971 that describes the tendency for humans to remember experiences with each other and to then modulate niceness based on who is likely or unlikely to reciprocate. The foundation enables mutually beneficial cooperation, was initially triggered by acts of cooperation or selfishness, and is modulated by cultural and political institutions. For example, liberals tend to focus on equality and social

justice, often through some degree of redistributive fairness or equality (i.e., everyone has an equal share), whereas conservatives tend to emphasize proportional fairness (i.e., equal earnings for equal work). It is associated with virtues of fairness, justice, and trustworthiness, and emotions of anger, gratitude, and guilt (Haidt, 2012).

3. Loyalty/Betrayal: A foundation associated with tribalism that evolved to prepare humans for "the adaptive challenge of forming cohesive coalitions" (Haidt, 2012, Kindle location 2517). This foundation enables humans to band together into groups that often maximize survival and is triggered by threats to group safety. It underlies virtues of loyalty, patriotism, and self-sacrifice and is associated with emotions of group pride and rage at traitors (Haidt, 2012).
4. Authority/Subversion: A foundation associated with the adaptive challenge of forging beneficial relationships within hierarchical human structures, originally triggered by signs of dominance and submission. It is associated with underlying virtues of obedience and deference and characteristic emotions of respect and fear (Haidt, 2012).
5. Sanctity/Degradation: A foundation that evolved to aid humans with the challenge of avoiding pathogens, diseases, parasites, and other contaminants and was originally triggered by waste products and diseased people but has generalized with time to taboo ideas (Haidt, 2012). It is associated with virtues of temperance, chastity, piety, and cleanliness and with the emotion of disgust (Haidt, 2012).
6. Liberty/Oppression: A foundation that evolved alongside the development of human language and the technology of weaponry, two tools that enabled human beings to police and, in some cases, overthrow individuals, including leaders, who violated social norms or bullied individuals and groups, creating a weak political egalitarianism within early

human tribes. It was originally triggered by signs of attempted domination, such as overly-controlling or aggressive behavior of an alpha male or female, producing a natural tension—and perhaps balance—with the Authority/Subversion foundation, and it is associated with emotions of reactance and resentment (Haidt, 2012).

MFT predicts that CMHCs of varying political ideologies will to some extent make different choices when reasoning about politically- or morally-charged issues because of differences in emphasis on certain universal moral foundations. If the current study finds differences between the perceived level of seriousness of politically-charged clinical issues as well as the selected treatment plan of objectives of CMHCs, then the study may be considered an addition to the body of research in MFT.

Additionally, MFT may provide a useful framework for discussion of the hypothesized differences. MFT offers a relatively nonjudgmental framework for exploring and conceptualizing the differences in moral reasoning and decision-making between and among political groups. Moral foundations theory is touted by Haidt, Graham, and Joseph (2009) as an "explanatory framework with which to understand the meaning of moral debates in the culture war" (p. 112). The theory not only helps people to understand how and why there are differences in moral reasoning between and within social groups; it portrays these differences as sensible, understandable, and perhaps valuable rather than dichotomous "right" and "wrong" perspectives. This tendency may open CMHCs, counselor educators, and researchers of varying belief systems up to learning about the moral reasoning of other groups in a less pejorative way. Haidt (2012) provides recommendations on how to have civil dialogue about differences in political and religious beliefs with people you disagree with that may be applicable in the counselor education arena as students, counselors-in-training, counselor educators, and clinical

supervisors of varying cultural backgrounds explore the impact of personal beliefs and biases on clinical practice. Graham, Haidt, & Novak (2009) conclude:

> Western societies are growing more diverse, and with diversity comes differing ideals about how best to regulate selfishness and about how we ought to live together. Participants in political debates are motivated in part by moral convictions. Moral foundations theory offers a useful way to conceptualize and measure such convictions. As research on political psychology thrives (Jost, 2006), we hope that it will clarify the role that morality plays in political thought and behavior (p. 1042).

When differences in moral reasoning between and among political groups are viewed through a less prejudicial lens, especially in a field that is disproportionately composed of individuals who describe themselves as liberal in political ideology, an environment is sometimes produced that is more conducive to free inquiry, open exchange, critical thinking, and broadened research focus. Such is the crux of the argument of Duarte et al. (2015), who opine that the ever-dwindling representation of conservatives and moderates in the field of social psychology results in the undermining of validity of research in the field. Perhaps this perspective could be useful in the field of clinical mental health counseling as well.

Definitions and Terms

Clinical mental health counselors (CMHCs) refers to counselors who specialize in clinical mental health counseling. For the current study, CMHCs will be operationally defined as active members of the American Mental Health Counselors Association (AMHCA) who are currently licensed as counselors in one or more states in the United States.

Clinical mental health counseling is defined by the American Mental Health Counselors Association (AMHCA, 2016) as:

> …The provision of professional counseling services involving the application of principles of psychotherapy, human development, learning theory, group dynamics, and the etiology of mental illness and dysfunctional behavior to individuals, couples, families and groups, for the purpose of promoting optimal mental health, dealing with normal problems of living and treating psychopathology. The practice of clinical mental health counseling includes, but is not limited to, diagnosis and treatment of mental and emotional disorders, psycho-educational techniques aimed at the prevention of mental and emotional disorders, consultations to individuals, couples, families, groups, organizations and communities, and clinical research into more effective psychotherapeutic treatment modalities" (p. 2).

Clinical vignette refers to "brief, carefully written description of a person or situation designed to stimulate key features of a real world scenario" (Evans et al., 2015, p. 162).

Communist refers to an adjective or noun describing political ideology advocating a society in which all property is publicly owned, and each person voluntarily works for the common good. In the current study, communism is operationally defined as the selection of the label "communist" when asked to describe political ideology.

Conservative is an adjective or noun referring to a political philosophy or worldview emphasizing a preference for traditional attitudes and values and cautiousness about change or innovation. In the United States, *political conservatism* generally refers to a preference for a limited federal government with limited spending and taxation and support of traditional values and ethics. In the current study, conservatism is operationally defined as the selection of the label "conservative" when asked to describe political ideology.

Counseling refers to "a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (Kaplan, Tarvydas, & Gladding, 2014).

Liberal is adjective or noun referring to a political philosophy or worldview emphasizing a preference for openness to new behavior or opinions and a willingness to discard traditional values. *Political liberalism* in the United States refers to a belief in a more expansive federal government that plays a substantial role in the welfare of the people. In the current study, liberalism is operationally defined as the selection of the label "liberal" when asked to describe political ideology.

Libertarian is an adjective or noun referring to a political philosophy or worldview upholding liberty as a core principle. Political libertarianism in the United States refers to a preference for a limited government with limited taxation and spending coupled with protection of individual liberties and choices with little or no government intervention.

Moral Foundations Theory is a social psychological theory intended to explain the origins of and variations in human moral, ethical, religious, and political reasoning on the basis of innate, modular foundations.

Political ideology refers to a set of beliefs about political theory and policy. For the current study, political ideology will be operationally defined as the participant's self-report label describing his or her political ideology (e.g., liberal, conservative, socialist, communist, unknown, and other).

Political party affiliation refers to the political party a participant is currently registered with (i.e., Republican, Democrat, Libertarian, Green, Constitution, No Party Affiliation, and other).

Seriousness of problems refers to the level or degree of demand for careful consideration or application and is operationally defined in the current study the numerical rating offered by participants on a scale ranging from 0 to 10 for how serious they believe a presenting issue in a clinical vignette is.

Socialist is an adjective or noun that refers to a preference for a government system prioritizing public, collective, or cooperative ownership of property and democratic control of ownership. It is often conceptualized as a midpoint between capitalism and communism. In the current study, socialist is operationally defined as the selection of the label "socialist" when asked to describe political ideology.

Treatment decisions refers to decisions made by CMHCs concerning treatment approaches and interventions. For the current study, treatment decisions will be operationally defined as treatment-related decisions selected by CMHCs to address presenting problems or concerns extrapolated from clinical vignettes.

Treatment plan refers to a plan developed by a CMHC outlining problems, goals, and objectives designed to aid clients with accomplishing mental health, wellness, education, and/or career goals.

Worldview refers to one's philosophy of life or conception of the world, which may include values, beliefs, and ethics.

Limitations and Delimitations.

Limitations for the current study include the following:

1. As with all online anonymous surveys, there is a risk of volunteer bias.

2. Ecological validity may be weakened as CMHCs may make different treatment planning decisions when working with their clients than they report they would make when responding to clinical vignettes.
3. The study is correlational and not causal. Thus, any causal conclusions are tentative at best.
4. A limitation in the use of clinical vignettes is that CMHCs may respond differently to similar vignettes with slightly different wording or phrasing.

One delimitation in the present study includes the exclusion of counseling students and interns who are not yet practicing independently in the community. In addition, in the present study no developed or normed test for political ideology was utilized to supplement the self-report of participants. Such measures are excluded to prevent the survey from becoming so lengthy or time-consuming that busy clinicians might be less likely to complete the full survey. Additionally, previous research findings have demonstrated that this measurement procedure accurately predicts voting behavior (Graham, Haidt, & Nosek, 2009; Haidt, 2012; Kanai et al., 2011). Finally, unlike the study conducted by Hersh and Goldenberg (2016), voter registration records will not be obtained. Instead, the self-report of participants regarding their voter registration status will be utilized in order to maintain the confidential nature of the survey design.

Chapter Two: Literature Review

Ethical codes in the clinical mental health counseling profession call upon CMHCs to be aware of their personal beliefs and values and how these beliefs impact their clinical practice. Additionally, these codes prohibit CMHCs from imposing their personal beliefs and values on their clients (ACA, 2014; AMHCA, 2015). Various historical events have led to this emphasis in the ethical codes. For example, homosexuality was once pathologized as a form of deviant or pathological behavior in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (APA, 1952; APA, 1963), but is now generally regarded within the mental health professions as a normal variation of human sexuality (Just the Facts Coalition, 2008). Prior to the decision to remove homosexuality from the DSM, many clients were treated with various therapies that were later regarded by the associations of mental health professions (i.e., American Association of Marriage and Family Therapy, American Counseling Association, American Mental Health Counselors Association, American Psychiatric Association, American Psychological Association, National Association of Social Workers) to be harmful to clients (AAMFT, 2017; AMHCA, 2014; Anton, 2010; APA, 2013; NASW, 2015; Whitman, Glosoff, Kocet, & Tarvydas, 2013). In more recent years, the ethical codes within the counseling profession were revised to clarify the importance of avoiding values imposition on clients in part as a reaction to two notable federal court cases in which counselors-in-training sued their graduate counseling programs for violations of their constitutional rights (i.e., freedom of speech and freedom of religion) because of punitive measures taken by their programs in

response to perceived ethical violations (Meyers, 2014). Specifically, in the case Ward v. Wilbanks a graduate counseling student was dismissed from her counseling program due to her assertion that perhaps she should refer a client to another counselor due to a clash between the client's presenting concerns involving a homosexual relationship and the student's Christian beliefs (Burkholder, Hall, & Burkholder, 2014), and in the case Keeton v. Anderson-Wiley a graduate counseling student verbalized support for conversion therapy aimed at helping clients change sexual orientation (DeMitchell, Hebert, & Phan, 2013). Perhaps in part as a reaction to ethical code revisions, some state legislatures have recently passed or attempted to pass legislation asserting the rights of licensed CMHCs to discriminate against LGBTQ clients (i.e., Ohio, Mississippi, and Tennessee) (ACA, 2016a; ACA 2018; Green, 2016), whereas several other states, primarily in the northeastern and western regions of the United States, have passed legislation banning conversion or reparative therapy in solidarity with the ethical positions of associations within the mental health professions (Movement Advanced Projects, 2019). The historical evolution of the mental health professions away from pathologizing LGBTQ clients towards affirming them, the related ethical code revisions and position statements prohibiting CMHCs from treating LGBTQ clients differently because of personal beliefs and values of CMHCs, and the subsequent legislative reactions, both supportive and oppositional to the associations' positions, serve as an illustration of the importance of research on the relationship between the political ideologies of CMHCs and their counseling practice. The present study will further this inquiry.

The literature review for the present study focused on four areas: (1) the relationship between personal, religious, and social beliefs of CMHCs and similar mental health professionals and their clinical practice; (2) the political beliefs of CMHCs and similar mental health

professionals; (3) the relationship between the political beliefs of mental health professionals and their counseling theories, and (4) the relationship between political ideologies of other healthcare practitioners not considered to be mental health professionals (i.e., primary care physicians) and their treatment decisions. Areas 1 and 4 have been included in the literature review due to the scarcity of research in area 3. Specifically, because such little research has been published directly examining the relationship between the political beliefs of CMHCs and their counseling practice, it is helpful to examine both the more robust presence of research on other types of social beliefs and counseling practice and a particular study examining this direct relationship among other types of health professionals.

Gladding and Newsome (2018) identified clinical social workers, clinical mental health counselors, marriage and family therapists, clinical and counseling psychologists, psychiatrists, and psychiatric nurse practitioners as licensed mental health professionals. Research focused on psychiatrists and psychiatric nurse practitioners is not considered, as the professional identity of those professions is more focused on medicine as compared to the other licensed mental health professions (Gladding & Newsome, 2018). The rationale for the inclusion of a study on primary care physicians (PCPs) involves the lack of research on the relationship between treatment decisions and political ideologies of any of the licensed mental health professions, including clinical mental health counseling.

These four research components are relevant to the questions posed by the present study based on the following logic. Although to date there appears to be no study examining the relationship between the political ideologies of CMHCs and their treatment decisions, previous research has demonstrated that: (a) other aspects of a CMHC's belief system may influence treatment approach; (b) there is a relative lack of political diversity among CMHCs as compared

to the general population; (c) there is a relationship between the political beliefs of PCPs and their treatment decisions, and the same may be true for CMHCs; and (d) deeper understanding of the possible relationships between the political ideology of CMHCs and their treatment decisions may expand the literature on counselor bias, possibly to the betterment of the profession. The focus of the literature review for this study adheres to this conceptual framework.

Research was conducted utilizing the *FindIt!* search engine of the University of South Florida's library digital collection using various keywords such as counseling, counseling theory, counselors, beliefs, political beliefs, political ideologies, attitudes, sexual orientation, religious beliefs, etc. The database's default timeframe setting of 1945 to present was maintained. Only studies with full access (vs. abstracts only) were utilized.

Impact of Counselors' Personal Beliefs on Practice

Ethical codes published by ACA and AMHCA call upon counselors to avoid imposing their attitudes, beliefs, and values on clients (ACA, 2014; AMHCA, 2015). These ethical precepts are related to the ethical value of autonomy, which involves "fostering the right to control the direction of one's life" (ACA, 2014, p. 3). Extensive research has unveiled a relationship between mental health professionals' personal, social and religious beliefs and their interactions and approaches with clients. For example, Cummings, Ivan, Carson, Stanley, and Pargamant (2014) conducted a narrative analysis and review of 29 articles published in peer-reviewed scholarly journals, concluding that therapist religiousness/spirituality positively correlated with favorable attitudes towards incorporating religiosity and spirituality into therapy, higher probability of implementing religious/spiritual interventions, higher levels of conservative social values, and less support for unconventional sexual behavior. However, the authors conceded that some of the studies they reviewed did not include information on the latter two

correlations (conservative social values and unconventional sexual behavior), cautioning that such conclusions are therefore tentative.

Barrett and McWhirter (2002) utilized multiple regression to identify correlations between client sexual orientation, counselor trainee gender, counselor trainee homophobia, and counselor trainees' perceptions of their clients as measured by the use of favorable and unfavorable adjectives for clients. They collected questionnaires from 162 counselor trainees in four public universities in the Great Plains of the United States. Participants were given a hypothetical client case description randomly assigned from one of four conditions that were identical in verbiage with the exception of the gender and sexual orientation of the client, which were organized into four conditions: (1) a gay male client; (2) a heterosexual male client; (3) a lesbian client; and (5) a heterosexual female client. Participants were asked to select adjectives describing the client from *The Adjective Checklist*. Client Homophobia, as measured by scores on *The Index of Homophobia*, significantly predicted the assignment of unfavorable adjectives for hypothetical client, $F(1, 160) = 4.28$, $p < .05$. Additionally, the intercept for gay men and lesbians differed significantly from the intercept for heterosexual men and women ($F = 3.82$, $p < .05$), indicating that counselor trainees were significantly less likely to describe heterosexual clients using unfavorable adjectives. In light of their findings, the authors suggested that counselor education programs facilitate more instruction and exploration of sexual orientation in graduate programs so that counselors-in-training are more aware of their homophobic attitudes towards clients. Although these may be significant findings for counselor trainees, it should be noted that the study excluded seasoned clinicians who were licensed to practice independently. Additionally, all of the participants were sampled from a particularly geographical location in the midwestern United States, posing the question of whether findings might differ in other regions.

In a survey of 766 participants in Florida, Bloom, Gutierrez, Lambie and Ali (2016) found that mental health counselors and marriage and family therapists who believed that pornography could be harmful to clients were more likely to assess for problems related to pornography and therefore more likely to treat those problems. After controlling for demographic variables, comfort with sexuality as measured by self-ratings on a five-point numerical scale and attitudes towards pornography as measured by scores on the Attitudes Towards Erotica Questionnaire (ATEQ) predicted counselors' treatment of client issues involving pornography, c^2 [7, N = 732] = 16.157, p = .024, and the model was statistically significant, c^2 [10, N = 732] = 38.011, p <.001. The researchers recommended that because counselors' attitude about pornography are predictive of assessment and, by extension, treatment of client issues related to pornography, counselors should ask their clients about pornography use through an intake questionnaire or during the initial interview. They also acknowledged the potential impact of social desirability and bias in their results as well as the low response rate of 6.9% (Bloom, Gutierrez, Lambie, & Ali, 2016).

Parikh, Post, and Flowers (2011) surveyed a national sample of 298 of 2,000 randomly selected members of the American School Counselors Association (ASCA). Using sequential multiple regression, they found that school counselors with lower levels of belief in a just world were as measured by scores on the Global Belief in a Just World Scale (GBJWS) were more likely to engage in advocacy behaviors for their clients measured by the Social Justice Advocacy Scale (SJAS) than counselors with a higher level of belief in a just world (defined as the belief that people get what they deserve and deserve what they get). Specifically, SJAS scores were statistically significant and positively related to religious ideology (r = .23, p < .001) and political ideology (r = .31, p < .001) and inversely related to BJW scores (r = -.25, p < .001).

Although the study was correlational in nature, findings raise the question of whether the degree of the counselor's belief in a just world influences or contributes to the likelihood that he or she will advocate for a client. Though the authors did not specifically discuss implications for the practice of school counseling in the field, they offered several recommendations for further research, including more detailed exploration of what social justice behaviors school counselors engage in, what values and beliefs school counselors-in-training bring into their education as compared to how those values and beliefs change during the course of education, and what specific characteristics of a counselor-in-training influence the likelihood of advocacy for a particular student (e.g., race, gender, socioeconomic status, and religion) (Parikh, Post, & Flowers, 2011).

Research has also demonstrated that counselors' personal beliefs about social issues influence their sense of competency in working with specific client populations. For example, Henke, Carlson, and McGeorge (2009) surveyed 741 clinical members of the American Association for Marriage and Family Therapy (AAMFT), finding that participants with higher levels of homophobia as measured by scores on the Modern Homophobia Scale (MHS) reported lower levels of competency in working with lesbian, gay, and bisexual clients as measured by scores on the Sexual Orientation Counselor Competency Scale (SOCCS) after controlling for demographic variables such as gender, sexual orientation approved supervisor status, years of clinical experience, prior work with lesbian and gay clients, number of lesbian and gay clients, highest level of education, and professional affiliation, $F(9, 524) = 27.47$, $p < .001$, $R^2 = .32$. In light of these findings, the authors suggested that AAMFT expand beyond its positions in support of equal rights for same-sex couples and non-discrimination by publishing more detailed and specific guidelines for therapists working with lesbian and gay clients and by providing more

specific requirements for instruction on sexual orientation in marriage and family therapy graduate programs (Henke, Carlson, & McGeorge, 2009).

Similarly, Bidell (2014) established an inverse relationship between religious fundamentalist beliefs as measured by scores on the Religious Fundamentalism Scale (RFS) and a categorical question assessing religious conservatism of 228 counselors-in-training sampled from 11 universities and self-reported competency working with lesbian, gay, and bisexual (LGB) clients as measured by scores on the SOCCS. ANCOVA was conducted, yielding a significant main effect for counselor religious conservatism on SOCCS scores, $F(4,220) = 2.78$, $p = 0.28$, $\chi^2 = .048$. Standard multiple regression using a model of RFS scores, LGB interpersonal contact, LGB trainings, and multicultural counseling coursework as significant predictors of SOCCS scores yielded a value of significant prediction, $R2 = .542$, $R^2_{adj} = .534$, $F(4, 222) = 65.74$, $p < .001$, with all predictor variables except multicultural counseling coursework contributing to the predictive model. Bidell (2014) noted, however, a study limitation consisting of the reliance on self-reported religious beliefs and counselor competency, which allow participants to give socially desirable responses as compared to additional measures such as evaluations from counseling supervisors, educators, or clients regarding competency. It is also noteworthy that the sample consisted of counselors-in-training with presumably limited experience rather than licensed counselors practicing independently in the field, raising the question of generalizability to a broader population of counselors. Additionally, the sample was self-selected rather than randomly selected, and causality ultimately cannot be determined from the study design. Nonetheless, Bidell (2014) identified several implications for the study's findings, proposing that (1) because mental health and psychosocial issues disproportionately affect lesbian, gay, and bisexual clients, (2) the primary ethical duty of counselors is to do no

harm, and (3) lesbian, gay, and bisexual clients who perceive that their counselors hold stigmatizing beliefs about sexual minorities may be less likely to disclose their sexual orientations and related concerns to counselors, it is important for counselors to be mindful of their biases.

In addition to religious beliefs and homophobia, ageism and beliefs about poverty have been explored in terms of the relationship between counselor beliefs and multicultural competency. McBride and Hays (2012) surveyed 360 counselors-in-training and master's- and doctoral-level counselors working in the field, all of whom were randomly selected from the membership of the American Counseling Association (ACA). The Multicultural Counseling Knowledge and Awareness Scale (MCKAS) was administered to measure multicultural counseling competence, and the Fraboni Scale of Ageism (FSA) was administered to measure ageism, defined as "stereotypes, prejudice, or discrimination against members of the geriatric population because of their age" (Butler, 1969, as cited in McBride & Hays, 2012, p. 79). A Pearson product-moment correlation coefficient demonstrated a significant and negative correlation between ageist attitudes of counselors and self-reported level of multicultural competency, $r(359) = -.41$, $p < .01$. When discussing their findings, the authors suggested that increased multicultural education in the form of integration of geriatric issues in core coursework in counselor education programs, conferences, experiential activities, greater client contact, additional coursework, and guided self-reflection and challenge of biases by counselor educators might facilitate a reduction in ageist beliefs among counselors (McBride & Hays, 2012). However, their discussion focused on implications for counselor education rather than on direct client care in clinical practice settings.

Clark, Moe, & Hays (2017) utilized hierarchical linear regressions to compare scores on the Multicultural Counseling Knowledge and Awareness Scale (MCKAS) with scores on the Beliefs About Poverty Scale (BAS) among a sample of 251 subscribers of electronic mailing lists within the counseling profession, concluding that multicultural counseling competence was predictive of counselor individualistic and structural poverty beliefs. Specifically, multicultural knowledge and awareness as measured by the MCKAS subscales significantly predicted individualistic poverty beliefs, $R^2 = .12$, $F(2, 243) = 16.95$, $p < .001$. The authors noted potential threats to internal validity, including selection bias, self-report bias, social desirability, extreme response bias, ordering bias, and measurement bias. Nonetheless, they identified several implications for counselor education and supervision. First, they observed that although the Council for Accreditation of Counseling and Related Educational Programs (CACREP) and the ACA emphasize multicultural competency in their respective standards for counselor education and clinical practice, it may be helpful for both to specifically mention social class and poverty in their standards. Second, they discussed the importance of both knowledge attained through instruction and awareness attained through experiential learning activities in training counselors to become culturally competent. Third, because they found no significant relationship between various personal and professional demographic factors and multicultural competencies, the role of appropriate multicultural training and education may be substantial regardless of the counselor-in-training's personal background (Clark, Moe, & Hays, 2017). Their discussion, however, focused primarily on implications for counselor education as opposed to clinical practice.

Several studies have specifically examined relationships between religious and spiritual beliefs of mental health professionals and their interactions with clients. In two quantitative

studies, 63 to 72 % of psychologists reported that their religious beliefs moderately or significantly influenced their practice of therapy (Bilgrave & Deluty, 1998; Bilgrave & Deluty, 2002). Though the authors of both studies asserted that their findings have an impact on the practice of psychotherapy and that therapists should regularly explore how their beliefs influence their clinical practice, neither manuscript described specific examples of how a lack of self-exploration might be detrimental to client care in a clinical setting. In a review of 29 quantitative studies on the religious and spiritual beliefs of psychotherapists, Cummings, Ivan, Carson, Stanley, and Pargamant (2014) concluded that religious and spiritual beliefs positively correlated with favorable attitudes towards integrating spirituality and religiosity in psychotherapy and with perceived competence in doing so. They also concluded that psychotherapists tend to prefer working with clients with similar spiritual and religious beliefs, and psychotherapists who endorse conservative social values are less likely to support unconventional sexual behavior. Additionally, clients who prefer to integrate religion and spirituality into their treatment are somewhat less likely to be accommodated by therapists who do not personally value religion and spirituality. Based on their findings, the authors speculated that standardized education focused on helping therapists in training incorporate religion and spirituality into their work may be helpful. They proposed that such training should educate therapists that many clients prefer to incorporate religion and spirituality into their therapy, that such incorporation can provide both resources and difficulties for the client, that treatment incorporating religion and spirituality are as efficacious as those that do not, and that such integration might improve client engagement, retention, and cultural relevance (Cummings et al., 2014). In consideration of religion and spirituality in counseling, the ethical precept that prohibits counselors from imposing their personal beliefs on clients swings both ways—counselors should neither impose their religious

and spiritual beliefs on their clients, nor should they impose personal biases against religion and spirituality on their clients who wish to incorporate those beliefs in their work.

Quantitative research that seeks to explore "what," "when," and "where" questions related to human behavior may be supplemented by qualitative studies that delve into "why" and "how" questions (Sheperis, Young, & Daniels, 2017) to form a more comprehensive picture of the relationship between counselors' beliefs and their clinical practice. Qualitative research has yielded additional relevant findings that religious and spiritual beliefs of counselors are related to their ability to empathize with and advocate for clients (e.g., Blair, 2015; Minnix, 2017; Morrison & Borgen, 2010).

For example, Blair (2015) interviewed nine mental health professionals in the United Kingdom in an attempt to better understand the relationship between counselor spirituality and counseling practice. Participants included six females and three males ages 42 to 85 (mean = 57.4; *SD* = 12.7), including three counseling psychologists, three psychotherapists, and three counselors, all of whom were accredited by the British Psychological Society, United Kingdom Council for Psychotherapy, or the British Association for Counselling and Psychotherapy. Participants worked in a variety of counseling settings, utilizing a variety of counseling theories. Themes of the interviews were classified into two major categories, including the direct influence of participants' spirituality on their therapeutic work and finding harmony between spirituality and broader professional context. Participants discussed a perception that their spiritual beliefs enabled them to better cope and self-regulate in sessions and to be more present and engaged with clients in the therapy room. Though participants generally expressed a belief in the importance of not imposing their spiritual beliefs on their clients, some also expressed that it is sometimes tempting to do so. Additionally, seven of the nine participants discussed a

willingness to disclose and discuss their spiritual beliefs with their clients if the client asks to discuss such information while also expressing an internal conflict in doing so. Participants also disclosed a tendency to find ways to incorporate their religious and spiritual beliefs into their counseling theories. After acknowledging that little can be generalized from one small qualitative study, Blair (2015) proposed that therapists adopt an "open and interested attitude" towards client spirituality" (p. 168), which should start with understanding their own spiritual perspectives and an appreciation for how the client's spirituality can be important for his or her self-care.

Minnix (2017) conducted a qualitative ground theory study with 15 heterosexual counselors who identified as Christians to explore the research question, "How did Christian heterosexual counselors who once perceived LGBT affirmation to conflict with their religious beliefs go about effectively reconciling this conflict to become LGBT affirming?" (Minnix, 2017, p. 117). "LGBT affirming" was defined as "the act of validating, supporting, and advocating for LGBT individuals, couples, and families" (Minnix, 2017, p. 111). The two primary obstacles to becoming LGBT affirming cited by participants included a risk of rejection by loved ones within counselors' families, social circles, and faith communities and the internalized importance of not questioning God (Minnix, 2017), thus illustrating how a counselor's religious beliefs can hinder client affirmation. Minnix (2017) further argued, however, that this study constituted evidence that counselors can successfully reconcile affirmation for LGBT clients and their conflicting Christian beliefs sufficient to be helpful to LGBT clients.

Morris and Borgen (2010) utilized critical incident technique methodology to explore how Christian spiritual and religious beliefs help and hinder counselors' empathy for clients.

They asked 12 counselors, including 3 men and 2 women, who held Christian beliefs and who believed that these beliefs influenced their counseling to recall incidents in which their religion or spirituality helped their empathy for clients as well as incidents in which they believe their religion or spirituality hindered their empathy. Participants were Canadian counselors practicing for at least five years, ages 28 to 70 (M = 48, Mdn = 51, SD = 12.8), recruited through the British Columbia Association of Clinical Counsellors representing a broad range of Christian religious identities. Collectively, participants identified 242 incidents in which they believed their religious beliefs or spirituality helped them to empathize with clients and 25 incidents in which they believed these beliefs hindered ability to empathize. Morris and Borgen (2010) then categorized helping incidents into 14 categories (i.e., relationship to faith leading to an empathic relationship with the client, connecting to the spiritual in the counseling relationship or the client, drawing on religious values of compassion, mercy and acceptance, following Jesus' example of empathy, spirituality informs ways of understanding the problem, similar life experiences, sharing the Christian culture, increased understanding of other cultures/religions/denominations, understanding one's own limits and boundaries, awareness or experiences of God's influence, shared humanity, empathy for the client because God cares for the client, empathy for the client because God cares for the counselor, the counseling process is similar to the faith journey) and hindering incidents into 3 categories (i.e., client's actions are contrary to the counselor's beliefs system, limited empathy as a result of counselor blind spots and biases, different expectations and shared religion). The authors concluded that although the study provided insight into how counselors believe their ability to empathize is helped or hindered by their spiritual beliefs, the next step in exploring clinical implications would be to explore clients or observe evaluations of counselors' empathy.

The authors of the aforementioned qualitative research articles rightly noted limitations inherent in qualitative research. For example, Blair (2015) acknowledged difficulty in generalizing from a small qualitative study. Additionally, Blair's (2015) sample consisted exclusively of counselors in the United Kingdom, raising the question about differences between national populations. Minnix (2017) discussed restrictions of interviewing only heterosexual Christian licensed mental health professionals in one geographical region (the southern United States), begging the question of generalizability to "other regions, demographic groups, LGBT individuals, or those of other (or no) religious affiliation" (p. 124). Morris and Borgen (2010) also acknowledge the limitation of difficulty generalizing from a small qualitative study design, adding additional limitations of the role of bias among participants and the ability of the design method to tap into more recent incidents at the possible expense of incidents that lie further in the participant's past. Despite the limitations of studies with a qualitative design, they provide additional evidence that many counselors both believe and are willing to specifically identify ways in which their religious and spiritual beliefs impact their counseling practice.

Political Ideologies of Mental Health Professionals

Research findings frequently support the observation that mental health professionals are more likely to self-identify as liberals than as conservatives (e.g., Bilgrave & Deluty, 2002; Norton & Tan, 2019; Parikh, Ceballos, & Post, 2013; Parikh, Post, & Flowers, 2011; Rosenwald 2006; Steele, Bischof, & Craig, 2014). To date, there appears to be only one study in the professional literature (i.e., Norton & Tan, 2019) that specifically examines the political ideologies of CMHCs as opposed to other mental health professionals (e.g., clinical social workers, clinical and counseling psychologists, marriage and family therapists, school counselors). Norton and Tan (2019) surveyed 467 licensed mental health counselors, obtaining a

sample by emailing a survey link to the 800 members of a state mental health counseling association chapter in the southern U.S. as well as to the 8,958 CMHCs who were currently licensed as mental health counselors in that state. Political party affiliation was measured by asking participants to self-report their current registered political party affiliation, revealing that CMHCs were more than 2.3 times as likely to be registered with the Democratic Party (n = 241, p = 54.28) than the Republican Party (n = 102, p = 22.97). Political ideology was measured by asking participants to identify their political ideology as liberal/progressive, conservative, moderate/centrist, libertarian, socialist, communist, anarchist or other. CMHCs were more than 2.6 times as likely to identify as liberal or progressive (n = 232, p = 50.99) than conservative (n = 89, p = 19.56%). Norton and Tan (2019) recommended that CMHCs strive to become more aware of how their political beliefs might impact their therapeutic approach with diverse clients. They further suggested that future research explore to what extent CMHC political ideology influences interactions with clients during therapy sessions, and whether the relative lack of political diversity among CMHCs adversely impacts research in counselor education, education and instruction of counselors-in-training, and the actions and positions of counseling associations on politicized issues.

An additional study explored the political ideologies of counselors in general, though not CMHCs specifically. Steele, Bischof and Craig (2014) randomly sampled 999 members of the American Counseling Association (ACA), half of whom were sampled from the ACA's counseling membership, and the other half of whom were sampled from the ACA's counselor educator membership with a combined response rate of 27.4 %. They utilized two measures for political characteristics, first asking participants to identify their political party affiliation as Republican, Democrat, independent, or other, and then asking participants to self-report whether

they think of themselves as extremely liberal, liberal, slightly liberal, moderate, slightly conservative, conservative, extremely conservative, or "haven't though much about this" (Steele, Bischof, & Craig, 2014, p. 454). These self-identification categories were duplicated from the American National Election Studies Time Series Study (ANES), a nationwide survey measuring political characteristics among the U.S. electorate since 1948, thus allowing for comparison of counselor political identification to the general population (Steele, Bischof, & Craig, 2014). Both counselor educators and counselors were approximately three times more likely to self-report that they were Democrats (p = .5347 and p = .50 respectively) as compared to Republicans (p = .18 and p = .17 respectively), and both groups were 2.3- to 2.7- times less likely to identify as Republicans (p = .18 and p = .17 respectively) than the general U.S. population (p = .41). Interestingly, however, counselor educators and counselors were more than twice as likely to identify their political party as "independent" (p = .2079 and p = .2411 respectively) as compared to the general U.S. population (p = .10), and they were about as likely to identify as Democrats (p = .5347 and p = .50 respectively) as compared to the general U.S. population (p = .49). With respect to self-reported political ideology, counselor educators and counselors were 2.4 times more likely to identify as liberals (p = .5346 and p = .5357 respectively) as compared to the general U.S. population (p = .22), and they were less likely to identify both as moderates (p = .1584 and p = .2143 respectively) and as conservatives (p = .2547 and p = .2054 respectively) as compared to the general U.S. population (moderate p = .26 and conservative p = .32) (Steele, Bischof, & Craig, 2014). Collectively, findings from this study suggest a picture of a counseling profession that is less Republican, more independent, equally Democrat, more liberal, less moderate, and less conservative as compared to the general U.S. population, though the usual limitations associated with self-selected survey study designs

apply. It is perhaps noteworthy that although this study was conducted with counseling professionals sampled from ACA membership, it is not possible to determine whether participants were CMHCs as opposed to other counselors, such as school counselors, rehabilitation counselors, and career counselors, as the ACA represents various counseling professions (ACA, n.d.). Comparatively, a sample obtained from AMHCA or from various state licensure boards for CMHCs would be more helpful in exploring the political affiliations of CMHCs. Though Steele, Bischof, and Craig (2014) offered a perspective on the implications of other findings in their study related to social justice, they did not discuss implications for the relative lack of political diversity within the counseling profession.

The political ideologies of school counselors have also been examined in previous research, though indirectly. Like CMHCs, school counselors are considered mental health professionals, and they are professional counselors trained in counseling interventions (American School Counselor Association, 2015). However, unlike CMHCs, they are generally not qualified to diagnose and treat mental disorders as healthcare practitioners (Gladding & Newsome, 2018). Parikh, Post, and Flowers (2011) surveyed 313 randomly selected members of the American School Counselor Association (ASCA), yielding a response rate of 15.7 %. Participants were asked to indicate whether by their own definitions they would consider their political views to be very conservative, conservative, somewhat conservative, somewhat liberal, liberal, or very liberal. Interestingly, however, the researchers did not report descriptive statistic related to participant responses on political ideology, perhaps because they were primarily interested in determining whether political ideology was predictive of social justice advocacy-related behaviors among school counselors.

In addition to the counseling profession, previous research has explored the political ideologies of psychologists. Bilgrave and Deluty (2002) surveyed 282 clinical and counseling psychologists sampled from the membership lists of five divisions of the American Psychological Association (APA), including the Clinical, Counseling, Psychotherapy, Humanistic, and Psychoanalysis divisions. Two methods of measuring political ideology included participant self-identification of current political party affiliation (Democrat, Republican, Independent, or other) and participant self-rating of political ideology on a 7-point scale ranging from 1 (very liberal) to 7 (very conservative). A majority of participants identified as Democrats (p = .67), followed by independents (p = .21) and Republicans (p = .08). In terms of self-identified labels of political ideology, participants were more likely to identify as liberal (p = .77) as compared to moderate (p = .14) and conservative (p = .09). Bilgrave and Deluty (2002) observed that the psychologists in their study were much more likely to self-identify as liberal and much less likely to self-identify as conservatives as compared to members of the general U.S. population as measured by National Election Study results yielding rates of 20% for liberal, 23% for moderate, and 30% for conservative political ideologies. Though implications for other aspects of their studies were discussed, the authors did not discuss implications for the relative lack of political diversity within the psychology profession.

The political ideologies of social workers have also been explored. For example, Rosenwald (2006) sampled 294 licensed social workers in Maryland, asking them to rate their political ideology on a seven-point scale ranging from radical right to radical left, revealing that 55.2% described their political ideology as between liberal and "radical left," whereas only 10.4% of participants described their political ideologies as ranging between conservative and "radical right, suggesting that social workers were more likely to identify with liberal political

ideology. However, a limitation of the study is its reliance on participants in one state, raising a question of generalizability on a national level. In terms of implications for the social work profession, Rosenwald (2006) argued that because only a "slim majority" (p. 124) (i.e., 53%) of participants ranked themselves as liberal or very liberal and more than a third of participants describing themselves as moderate, the stereotype of a profession "dominated by liberal political ideology" (p. 124) is overly simplified and exaggerated.

Parikh, Ceballos, and Post (2013) surveyed 448 members of the Association for Play Therapy (APT). Because members of APT include licensed mental health professionals, school counselors, and psychologists, and students in these professions (APT, 2013), this sample is likely a multidisciplinary sample of mental health professionals. Participants were asked to identify their political ideologies based on categories including very conservative, conservative, somewhat conservative, somewhat liberal, liberal, and very liberal. Participants were more 2.7 times more likely to self-identify as liberal ($n = 327$, $p = .73$) as compared to conservative ($n = 121$, $p = 0.27$). Though the researchers commented on implications for relationships between political ideology and other constructs of interest in their study (i.e., attitudes about social justice), they did not discuss any other implications directly related to the relative lack of political homogeneity within the profession.

All of the above studies used self-reported survey measures, and the method of inquiry for political ideology typically involved little more than a self-reported label, posing a potential limitation. For example, it is possible that many CMHCs apply labels or words to describe their political ideologies that don't accurately represent their political beliefs. Additionally, most studies rely on sampling from the memberships of professional associations in the mental health professions, but we do not know for certain if members of associations are politically similar or

dissimilar to mental health professionals who choose not to join professional associations. It is possible, for example, that liberal mental health professionals are more likely to join associations.

However, assuming that the self-report of participants in the above studies is relatively accurate and that the membership of mental health professional associations is relatively representative of practitioners-at-large, it is apparent that mental health professionals are significantly less politically diverse than the overall population. For example, the Gallup Poll, which polls the U.S. population on self-description of political ideology every year, indicates that 36% of Americans label themselves as conservative and 25% label themselves as liberal (Saad, 2017). Gallup also reports that as of July 2017, 28% of Americans reported that they were registered Democrats, 25% reported they were Republicans, and 45% reported that they were independents (Gallup, 2017). Collectively, research in this area has yielded a finding that over half of mental health professionals (i.e., 51 % to 77 %) described themselves as liberal, whereas only 9 to 25 % describe themselves as conservative, suggesting a substantially more liberal population than the general U.S. population as measured by ANEP and Gallup results, which depict conservatives as composing 30 % to 36 % of the general population and liberals as composing 20 % to 25 % of the population. Similarly, research findings depict the mental health professions as more likely to be Democrat (54-67%) than Republican (8-23%) as compared to the general U.S. population, which is generally reported as 28 % to 49 % Democrat and 25 % to 41 % Republican. The finding that the mental health professions and related social science professions lack political diversity in comparison to the general population has been cited in research as having the potential for implications affecting limited focus and bias among researchers, potential instruction bias and professional gate-keeping on the part of counselor

educators, and the potential effect on positions taken by professional associations on politicized issues (e.g., Duarte et al., 2015; Galambos, 2009; Norton & Tan, 2019; Redding, 2001; Rosenwald, 2006; Tetlock & Mitchell, 2015).

Political Beliefs of Mental Health Professionals and Their Counseling Theories

To date, two studies have been identified that examine a relationship between the political ideologies of mental health professionals and their preferred counseling theories. The first is the aforementioned study conducted by Bilgrave and Deluty (2002) in which 282 clinical and counseling psychologists sampled from the membership lists of five divisions of the American Psychological Association (APA), including the Clinical, Counseling, Psychotherapy, Humanistic, and Psychoanalysis divisions were surveyed. The variables explored included political ideology and counseling theory, though other variables not relevant to the current paper were also explored. Two formats were developed to assess the preferred counseling theories of participants. The first was a forced-choice item asking participants to select their preferred counseling theory from four categories, including cognitive-behavioral, psychodynamic-psychoanalytic, humanistic-person-centered-experiential, and existential. The second involved asking participants to rate their level of commitment to the aforementioned four categories of counseling theory using a 5-point Likert-type scale ranging from no commitment to very strong commitment. Three methods of measuring political ideology included participant self-identification of current political party affiliation (Democrat, Republican, Independent, or other), participant self-rating of political ideology on a 7-point scale ranging from 1 (very liberal) to 7 (very conservative), and scores on Kerlinger's Referents Scale (REF-VI). Using multiple regressions, researchers concluded that: (1) liberalism, as measured by scores on the liberal political referents derived from the REF-VI, along with three other variables (i.e., Eastern-

mysticism, atheist/agnostic beliefs, and belief in science) predicted commitment to humanistic counseling theory, ß = 0.06, $p < .01$; (2) political conservatism did not predict adherence to cognitive-behavioral theory (ß = -0.12, $p = .08$), though age (i.e., younger age), conservative Christianity, and higher belief in science did; and (3) liberalism predicted commitment to psychodynamic theory (ß = 0.06, $p < .01$), along with older age, self-identification as female, lower agreement with Eastern and mystical religious beliefs. It is also noteworthy that nearly half of participants reported a belief that their political ideologies influenced their practice. In terms of implications for clinical practice, the authors proposed that the finding that religious and political beliefs predicted psychotherapeutic interventions challenged the prevailing scientist-practitioner model in the field of psychology, which emphasizes science as the only legitimate means of finding truth in the world. They proposed that from a postmodern perspective, these findings are not inherently problematic, and they recommended that graduate programs in the therapeutic professions ask their students to uncover, evaluate, and articulate their religious and political beliefs throughout their education. Lastly, they recommended that both students and practitioners in the field regularly explore how their political or religious beliefs impact various aspects of clinical practice (Bilgrave & Deluty, 2002).

By yielding statistically significant relationships between liberal political ideology and commitment to psychodynamic and humanistic counseling theories, Bilgrave and Deluty (2002) opened the door for further inquiry with respect to the question of how a mental health professional's political ideology may influence his or her treatment approaches. Consequently, Norton and Tan (2019) investigated whether such relationships might also apply to CMHCs. They surveyed 467 licensed mental health counselors, obtaining a sample by emailing a survey link to the 800 members of a state mental health counseling association chapter in the southern

U.S. as well as to the 8,958 CMHCs who were currently licensed as mental health counselors in that state. Participants were asked to rate their preference for six counseling theory categories (i.e., cognitive-behavioral, psychodynamic-psychoanalytic, humanistic-constructivist-existential, mindfulness-based, experiential, and systemic on a scale from 1 (least preferred) to 6 (most preferred). Political ideology was measured in three ways, including self-report of registered political party, self-reported label for personal political ideology (i.e., liberal/progressive, conservative, moderate/centrist, libertarian, socialist, communist, anarchist, and other), and self-rated level of agreement with 14 political statements based on questionnaires used in previous studies. General linear modeling (GLM) was used to calculate associations between party affiliation, political ideology, and political beliefs and preferences for each of the six counseling theory categories using gender, ethnicity, age, and number of years licensed as covariates. Democrats scored .34 points lower on preference for cognitive-behavioral theory, and participants registered with the Democratic Party scored .26 points lower on preference for cognitive-behavioral theory. Liberal/progressive participants scored .73 points ($p < .001$) lower on preference for cognitive-behavioral theory and .44 points ($p < .01$) higher on preference for psychodynamic theories as compared to conservative participants. Higher levels of endorsement of libertarian political beliefs were associated with a stronger preference for cognitive-behavioral theory ($ß = .20$, $p < .05$) and a lower preference for humanistic theories ($ß = -.22$, $p < .01$). Additionally, nearly 70% of participants reported a perception that their political ideologies influenced their counseling theories to at least some extent, which was 20% higher than the sample of psychologists surveyed by Bilgrave & Deluty (2002).

In addition to expanding the focus of research on the relationship between political ideology and counseling theory from psychologists to CMHCs, Norton and Tan's (2019) study

adds a benefit of not exclusively relying on membership of professional associations for sampling, perhaps reducing the potential for biased responses based on differences in the average political makeup of association members as opposed to practitioners working in the field. The authors cited limitations for their study, including the usual potential for sampling bias when collecting responses via email survey and the question of generalizability from a southern state to the rest of the country. An additional limitation is the question of whether a relationship between counseling theory and political ideology actually translates into any different in-the-therapy-room practices between counselor and client, as well as to what extent such differences might actually affect client care or therapy outcomes. In fact, this is one of the questions posed by the researchers in their discussion, along with questions of whether and how the relative lack of political diversity among CMHCs might affect research and instruction in counselor education and the positions of counseling associations. In terms of clinical implications, Norton and Tan (2019) recommended that CMHCs strive to be mindful of the nature of their political beliefs and how these beliefs impact therapy. Regarding implications for research in counselor education, they recommended additional studies using a variety of study designs be conducted, particularly given that their study was the first to explore the relationship between political beliefs of CMHCs and their counseling theories. They proposed additional research exploring related research questions including whether clients with different political beliefs have different treatment outcomes when matched with CMHCs with different political beliefs, whether relative political homogeneity translates into bias within counselor education research (e.g., biased verbiage in questionnaires, lack of focus on research issues that might be more relevant to conservative CMHCs), and whether and how bias manifests itself in graduate programs training CMHCs (e.g., gatekeeping by liberal professors, biased or one-sided lectures, etc.). Finally, they

recommended that political bias among CMHCs be explored in terms of the actions and positions of counseling associations (Norton & Tan, 2019).

Political Beliefs and Treatment Decisions of Other Healthcare Practitioners

Hersh and Goldenberg (2016) sampled 233 primary care physicians (PCPs) in the 29 states that provide public listings of the political party affiliations of registered voters. They asked participants to describe their political ideology as very liberal, liberal, moderate, conservative, very conservative, or not sure. They cross-referenced participant responses with voter registration records to determine political party affiliation. They provided participants with nine clinical vignettes related to politicized and nonpoliticized issues and asked them to rate how serious they considered each presenting problem on a 10-point scale, provided them with options of how to address each scenario in terms of a treatment decision. Using histograms, differences of means, and regression analysis controlling for physician age, gender, and religious attendance, they concluded that there were no significant differences between participants registered as Republicans and those registered as Democrats in the perceived seriousness of behaviors and presenting problems that were not suspected by the researchers to be politicized (i.e., heavy alcohol consumption, tobacco use, riding a motorcycle without a helmet, obesity of a patient who doesn't exercise, depressive symptoms, and sexual intercourse with sex workers). However, there were statistically significant differences between the two groups on more politicized issues. Specifically, Republican PCPs expressed more concern than their Democratic colleagues for vignettes in which patients acknowledged using recreational marijuana three times a week and reported a history of two elective abortions in the past year, whereas Democratic PCPs expressed more concern for a vignette in which a patient with two small children acknowledged having several firearms in the home. There were also notable differences on the selected treatment plan

objectives of Republican and Democratic PCPs. Overall, PCPs who were registered Republicans were more likely to report that they would discuss health risks associated with marijuana use, abortion, and sex with sex workers than PCPs who were registered as Democrats. In the vignette related to firearms, Republican PCPs were more likely to encourage safe storage of firearms, whereas their Democratic colleagues were more likely to discourage the patient from storing a firearm anywhere in the home (Hersh & Goldenberg, 2016). This study suggests that political beliefs of PCPs influence their treatment approaches, begging the question of whether the same might be true for other healthcare practitioners, including CMHCs.

These findings should be interpreted in light of several limitations. First, the researchers offered no explanation for why some issues were hypothesized to be politicized (i.e., marijuana use, abortion, and firearm storage) and others were not (i.e., heavy alcohol consumption, tobacco use, riding a motorcycle without a helmet, obesity of a patient who doesn't exercise, depressive symptoms, and sexual intercourse with sex workers). Additionally, the researchers acknowledged a non-representative sample (i.e., PCPs registered as Democrats were more likely to respond to surveys than those registered as Republicans). Instead of asking PCPs to self-report their party affiliation, the researchers matched participant names to public voting records. This method may have reduced the likelihood of response priming, a phenomenon in which a participant's response is influenced by a question posed earlier. If, for example, the researchers first asked participants a series of questions about their political affiliation and then posed questions about politicized issues, participants may have responded differently because they were more likely to be thinking about their political beliefs than they would in a real-world clinical encounter. However, the researchers were unable to match some participants to public voting records, which could have potentially resulted in reporting bias. Additionally, the results

may have been more relevant if the researchers expanded their focus beyond political party affiliation to political ideology (i.e., conservative, liberal, moderate, libertarian, socialist). Many members of political parties espouse viewpoints that differ substantially from party leadership or platform (Feldman & Johnston, 2014), and dichotomous political categorizations have been criticized as an oversimplification and a limitation in political science and social psychological research (e.g., Bryson, 1968; Jost, Federico, & Napier, 2009; Feldman & Johnston, 2014; Kerlinger, 1984; Treier & Hillygus, 2009).

Hersh and Goldenberg (2016) acknowledged the potential for misreporting bias in any study using a clinical vignette survey design, adding that "survey vignettes have been validated as strong indicators of actual clinical practice" (p. 4). Despite this potential for bias, many studies have validated clinical vignettes as valid and reliable methods of assessing clinical practice (Evans et al., 2015; Jeffries & Maeder, 2005), but not all vignettes are created equal. A brief overview of validity considerations for the use of vignettes in clinical research is warranted. A clinical vignette is a "brief, carefully written description of a person or situation designed to stimulate key features of a real-world scenario" (Evans et al., 2015, p. 162). Evans et al. (2015) offer 15 recommendations for enhancing content validity of clinical vignettes, offering that vignettes should:

1. Derive from the literature and/or clinical experience.
2. Be clear, well-written, and carefully edited.
3. Not be longer necessary (typically between 50 and 500 words).
4. Follow a narrative, story-like progression.
5. Follow a similar structure and style for all vignettes in this study.
6. Use present tense (past tense only for history and background information)

7. Avoid placing the participant "in the vignette" (e.g., as first-or third-person character)
8. Balance gender and age across vignettes.
9. Be as neutral as possible with respect to cultural and socio-economic factors.
10. Resemble real people, not a personification of the list of symptoms or behaviors.
11. Be relatable, relevant, and plausible to participants.
12. Avoid "red herrings," misleading details, and bizarre content.
13. Highlight the key variables of interest, facilitating experimental effects.
14. Facilitate participant engagement and thinking by including vague or ambiguous elements.
15. Cover all pertinent variables (or omit selected variables for specific purposes).

(Evans et al., 2015, p. 165).

Summary of Literature Review

Despite the limitations of correlational research and survey methods, the above findings offer an emerging picture of a counseling profession in which the personal beliefs of CMHCs likely influence their treatment approach, regardless of whether CMHCs are aware of the influence. The ethical codes in the counseling profession call upon CMHCs to be aware of their personal beliefs and values, as well as to avoid imposing their beliefs on the clients (ACA, 2014; AMHCA, 2015), and previous research supports the finding that the beliefs and values (e.g., religious and spiritual beliefs, belief in a just world, homophobic attitudes, beliefs about sexuality and pornography, ageist beliefs, beliefs about poverty, political beliefs) of various mental health professionals, including CMHCs, impact different aspects of their work, including the likelihood of incorporating religiosity and spirituality into therapy (e.g., Cummings, Ivan,

Carson, & Pargamant, 2015), the use of unfavorable adjectives describing sexual minority clients (Barrett & McWhirter, 2002), the likelihood of assessing and treating problematic use of pornography (Bloom, Guiterrez, Lambie, & Ali, 2016), the likelihood of engaging in social justice advocacy behaviors (Parikh, Post, & Flowers, 2016), self-reported levels of competency working with sexual minority clients (e.g., Bidell, 2014; Henke, Carlson, & McGeorge, 2009), self-reported levels of multicultural competency (Clark, Moe, & Hays, 2017; McBride & Hays, 2012), and preferences for particular counseling theories (Bilgrave & Deluty, 2002; Norton & Tan, 2019).

The above research, however, tells very little about how the personal beliefs and values of CMHCs are related to specific treatment interventions in the context of psychotherapy, such as chosen treatment plan objectives. Despite the lack of research on the relationship between the political ideologies of CMHCs and their treatment decisions, one study (i.e., Hersh & Goldenberg, 2016) found a relationship between the political party affiliation of PCPs and their treatment decisions, posing the question of the whether a similar relationship might exist with other healthcare professionals, such as CMHCs. Collectively, previous studies (e.g., Bilgrave & Deluty, 2002; Norton & Tan, 2019; Parikh, Ceballos, & Post, 2013; Parikh, Post, & Flowers, 2011; Rosenwald 2006; Steele, Bischof, & Craig, 2014) have established that mental health professionals, including CMHCs, are more politically homogenous than the general population.

In summary, the existing research (a) emphasizes the importance of CMHCs' awareness of how their personal beliefs impact their work, and (b) supports the finding that various beliefs and values impact aspects of CMHCs' work. However, to date no study identified in the literature has examined how the political beliefs of CMHCs influence specific treatment plan

interventions involved in psychotherapy. The current study aimed to pioneer a branch of research in counselor education that fills this gap.

Chapter Three: Methods

Design

I used a quantitative approach incorporating a correlational survey design utilizing comparison of means and multiple regression statistical analysis for the present study. This design was utilized because a quantitative approach was expected to provide the most direct answer to the question of whether there is a statistical correlational between the independent variables of political ideology and political party affiliation of CMHCs and their treatment decisions. Multiple regression analysis is appropriate for the current study because I examined the extent to which multiple independent variables predict a single dependent variable (Sheperis, Young, & Daniels, 2017). I utilized an anonymous online survey because of its ease of use and administration, reduction of privacy concerns, and greater likelihood of yielding a large sample size for statistical power. The following section describes the methods for developing the survey, recruiting participants, administering the survey, and analyzing survey data. Additionally, the previous study conducted by Hersh and Goldenberg (2016), which inspired the current study, utilized a quantitative, correlational, anonymous online survey design, and consistency in the current study design will allow for a more effective comparison of results between studies.

Sampling

To be eligible for participation in the study, participants were required to have current and active state licenses as counselors in the United States and to be members of the American

Mental Health Counselors Association (AMHCA). AMHCA was utilized as it is the largest national association that exclusively represents CMHCs. Survey access was restricted to currently licensed CMHCs to ensure against the inclusion of counseling students and interns who were not able to practice independently in the field. Utilizing G*Power, an *a priori* estimation of sample size for an effect size of 0.2, alpha error rate of 0.05, power of 0.95, and five predictors yielded an estimate of 105 participants (Faul, Erdfelder, Buchner, & Lang, 2009). Although the minimum number of participants for the study was therefore set to 105, my goal was to secure a larger sample size as was accomplished with a prior study on the relationship between the political ideologies of counselors and their preferred counseling theories (Norton & Tan, 2019).

Ethics

Because the survey was anonymous and the content of the survey was unlikely to generate psychological distress among participants, the risk for ethical breeches in administration was very low. However, incomplete disclosure was used in the consent to participate. Participants were informed that the purpose of the study was to explore treatment decisions of CMHCs, but they were not informed of the focus on political ideology and party affiliation in order to avoid influencing the responses of the participants through priming.

Data Collection Procedures

Participants were solicited through a recruitment post on AMHCA's community forum. At this writing, there are approximately 5,700 members of AMHCA. Reminder messages were posted 7 and 14 days later, and the survey was closed 30 days after the original post. The survey was conducted via Qualtrics. Responses were collected between December 6, 2019 and January 19, 2020.

Instrumentation

The survey adapted from Hersh and Goldenberg's (2016) study with PCPs but with slight modifications in verbiage such that items were more applicable to CMHCs and with three added scenarios (see Survey Content). To establish face and content validity, three counselor educators with expertise in both clinical mental health counseling and research in counselor education were asked to review both the original survey used in Hersh and Goldenberg's (2016) study and the revised survey to be used in the current study. Reviewers were asked to rate each item on a sale from 1 to 5 in terms of relevance, representativeness, specificity, and clarity (Haynes, Richard, & Kubany, 1995). Initially, two of the three reviewers rated the items for all 11 vignettes as "very relevant," whereas one reviewer rated all vignettes as "very relevant" with the exception of the gun storage and obesity scales, which were rated as "somewhat irrelevant" and "moderately relevant" respectively. However, the dissenting researcher amended her rating as "very relevant" after reviewing the survey used by Hersh & Goldenberg (2016) and considering the items within the context of providing a close fit to the previous study. One reviewer suggested revising one item in vignette #1 (alcohol) and another in vignette #2 to include additional recovery group options that are not based on the 12-step model. Because this recommendation appeared reasonable, consistent with common practice in the field, and unlikely to detract from the intended function of the two items (i.e., referring a client to an appropriate support group), the items were revised as follows: (1) "Refer the client to Alcoholics Anonymous, Celebrate Recovery, SMART Recovery, LifeRing, or a similar peer support group;" and (2) "Refer the client to Narcotics Anonymous, Marijuana Anonymous, Celebrate Recovery, SMART Recovery, or a similar peer support group."

Treatment decision options were organized into scales for each clinical vignette and averaged on a 10-point scale to simplify statistical analyses. Cronbach's alpha was calculated as a measure or internal reliability (Cronbach, 1951), yielding values ranging from .61 to .91 per scale (see Table 1). The majority of items on each scale involve the application of an intervention designed to address a clinical problem (e.g., discussing health risks for a behavior, urging a client to change behavior, referring the client to a resource, offering coping strategies). However, two items described actions that involve a reduction in intervention, including (1) Explain that you do not write letters attesting to the need for emotional support animals; and (2) Explain that you do not write letters attesting to sex reassignment surgeries. Therefore, those items were reverse-coded. Accordingly, higher scores on the treatment decision scales reflected CMHCs doing more to address a problem as opposed to doing less.

Table 1. Internal Reliability of Treatment Decision Scales

Scale	*Cronbach's alpha*	Number of Items
Alcohol	.86	5
Cannabis	.89	5
Tobacco	.91	5
Sex worker	.89	7
Depression	.61	5
Gun ownership	.68	3
Obesity	.91	8
Abortion	.83	5
Lesbian adoption	.70	8
Emotional support animal	.73	8
Gender dysphoria	.76	6

Survey Content

The survey included four types of questions (see Appendix A). First, respondents were asked about several demographic questions, such as age, sex/gender, race/ethnicity, sexual orientation, number of years in practice, primary practice setting, state(s) in which the participant is licensed to practice, and religious affiliation(s). Race and ethnicity options will be identical to those used by the United States [U.S.] Census Bureau (U.S. Census Bureau, n.d.). Work setting categories were be consistent with categories identified in studies of professional counselors conducted by the American Counseling Association (e.g., ACA, 2014b). Religious affiliations were consistent with categories used in national Gallup surveys (Gallup, n.d.).

Second, two questions about political characteristics were embedded in the demographic section. Specifically, participants were asked to identify their political ideology and were offered the following options: libertarian, conservative, liberal, socialist, communist, and other. Participants were also asked to identify which political party they are currently registered under, using the nine major political parties in the United States as identified by the American Democracy Project of the American Association of State Colleges and Universities (AASCU) (i.e., Constitution Party, Democratic Party, Democratic Socialists of America, Green Party, Independent Party, Libertarian Party, Reform Party, Republican Party, and Tea Party) (AASCU, n.d.). Additional options of no party affiliation, not registered to vote, and unknown were available.

Third, participants were given a list of topics that are often incorporated into biopsychosocial assessments in counseling environments and were asked how often they inquire about these subject areas (i.e., never, rarely, sometimes, usually, and always). These topics were identical to those included in the Hersh and Goldenberg (2016) study with the following exceptions to ensure relevancy to CMHCs as opposed to PCPs: (1) “mental health” was removed

as it was presumed that all CMHCs ask about mental health in an assessment; (2) "use of seatbelts" and "use of helmets" were removed; and (3) "sexual orientation" and "gender identity" were added as they are related to two vignettes that were added to the present study but were not included in Hersh and Goldenberg's (2016) study. As with the previous study, participants were also be asked whether their practices provide them with guidelines and/or checklists of topics to cover in an initial assessment or whether the participant has sole discretion in this area.

Fourth, participants were given five clinical vignettes that relate to politicized issues that CMHCs may face in their counseling practices. Clinical vignettes have been identified as a useful tool in the social sciences and in clinical professions because they are relatively easy to construct, stimulate discussion on focused topics, provide a less threatening means to explore sensitive and controversial topics, and reflect "real-life contexts and problems" (Jeffries & Maeder, 2004, p. 17). Clinical vignettes were based on the study conducted by Hersh and Goldenberg (2016) that served as the inspiration for the current study. However, the Hersh and Goldenberg (2016) surveyed PCPs, the vignettes were modified to better relate to the scope of practice of CMHCs. For example, the word "patient" was replaced with the word "client" as "client" is the term used in the ethical codes of CMHCs (e.g., ACA, 2014a; AMHCA, 2015). Instead of indicating that the client is presenting for a physical, the client was indicated as presenting for an initial interview. Because PCPs often see their patients rarely in comparison to CMHCs, and because CMHCs often utilize the first appointment for assessment rather than intervention, the verbiage "If you would discuss the behavior with the patient" was replaced with "If you would discuss this behavior with the client during the initial interview or in subsequent appointments."

Next, three questions were added to reflect additional controversial topics in the clinical mental health counseling profession, including assessment of the need for emotional support animals (Boness, Younggren, & Frumkin, 2017; Younggren, Boisvert, & Boness, 2016), the provision of couples therapy for gay and lesbian clients (Meyers, 2014), and therapy for transgender clients seeking sex-reassignment surgery (Carlozzi, 2017). Because the emotional support animal and gender reassignment scenarios exclusively relate to assessment-related procedures, the questions about perceived level of seriousness of a problem and likelihood of documenting the issues in the client's record were omitted.

After each vignette, participants were asked three questions: (1) On a scale from 1 to 10, how serious of a problem do you think _____is? (The blank denotes the topic of the particular vignette); (2) "Would you typically document this behavior in the client's record and/or discuss it further with the client? (check all that apply)," which was followed by the following options: I would document this behavior in the client record; I would discuss this behavior further with the client; and/or I would neither document this behavior in the medical record nor discuss this behavior further with the client unless I saw more reason to do so; and (3) If you would discuss the behavior with the client, would you: [intervention options listed]. Participants were then given several options for treatment plan objectives related to the presenting problem in the vignette (see appendix A vignettes).

The items were duplicated from the previous study by Hersh and Goldenberg (2016) with some revisions to make the items more applicable to CMHCs as opposed to PCPs. For example, treatment options that involve prescribing a medication to a client were re-worded as referral to a physician to consult about medication options as prescription of medication is beyond the scope of practice of CMHCs (AMHCA, 2016). The option "refer the patient to counseling options"

was removed because in each scenario the client is already seeing a counselor. In scenarios 2, 5, 6, and 8, referral to addiction recovery groups or peer support groups were added to be consistent with scenario 1's option of referral to Alcoholics Anonymous as well as to provide an option for CMHCs who may be prone to conceptualize cases from an addiction/recovery or peer support model. In scenario 5, "screen for sexually transmitted diseases" was replaced with "screen for sexually transmitted infections and/or refer to a clinic for testing" as CMHCs are often qualified to ask screening questions but lack the medical expertise for further testing as compared with PCPs. In scenario 6, the verbiage "suggestive of a moderate level of depressive symptoms" was added because some CMHCs may not have been trained on interpretation of PHQ-9 scores. Similarly, on an item providing a body mass index (BMI) score for a client, the verbiage "indicative of obesity" was added as some CMHCs may not be trained on interpretation of BMI scores.

Data Analysis Plan

Upon termination of data collection, an initial total of 168 responses out of a possible 1,143 were received, making the response rate 14.69 %. However, this response rate is a conservative estimate, as AMHCA staff clarified that there is no way to know how many of the 1,143 members who accessed the forum on the date of the post actually saw, read, or clicked on the post (Whitney Meyerhoeffer, personal communication, March 1, 2021).

For research question #1 (relationship between reported political ideology and perceived level of seriousness of clinical problems) and research question #2 (relationship between reported political party registration and perceived level of seriousness of clinical problems), multiple regression was utilized. The independent variable for question #1 is reported political ideology, the independent variable for question #2 is reported political party registration, and

five extraneous variables were controlled for (i.e., age, gender, race, ethnicity, and religious affiliation).

For research question #3 (relationship between reported political ideology and selected treatment plan objectives) and research question #4 (relationship between reported political party registration and selected treatment plan objectives), multiple regression was utilized. The independent variable for question #3 was political ideology, the independent variable for question #4 was political party registration, and five extraneous variables were controlled for (i.e., age, gender, race, ethnicity, and religious affiliation). SPSS was used to perform all statistical tests.

For all regression analyses, assumptions of multiple regression were evaluated using the following procedure. To ensure there was no multicollinearity in the data, Pearson correlations were examined, revealing that no values fell outside the range of -0.40 and 0.40. To ensure that the values of residuals were independent, the Durbin-Watson statistic was examined, and all values fell between 1 and 2. To ensure that the variables of the residuals were constant and test the assumption of a linear relationship between dependent variables and the independent variable, scatterplots were examined, revealing no violations of homoscedasticity. Standardized residuals and skewness and kurtosis values were examined to ensure values fell between or near the range of -3 and 3, and histograms were examined to ensure a normal curve.

Chapter Four: Results

The purpose of this study was to explore the relationship between the political ideologies, political party affiliations, and treatment decisions of clinical mental health counselors (perceived level of seriousness of clinical problems related to politically charged subject matter and selected treatment plan objectives). A better understanding of this relationship might lead to increased understanding the impact of counselor bias on clinical practice.

The research questions were as follows:

(1) What is the relationship between CMHCs' reported political ideology (i.e., conservative as compared to all other political ideologies) and their perceived levels of seriousness of problems related to politicized issues (e.g., marijuana use, abortion, gay adoption, firearms, sex reassignment)?

(2) What is the relationship between the reported political party (i.e., Republican as compared to all other political parties) of CMHCs and their perceived levels of seriousness of problems related to politicized issues (e.g., marijuana use, abortion, gay adoption, firearms, sex reassignment)?

(3) What is the relationship between the reported political ideology (i.e., conservative as compared to all other political ideologies) of CMHCs and their treatment decisions about case examples that involve politicized issues (e.g., marijuana use, abortion, gay adoption, firearms, sex reassignment)?

(4) What is the relationship between the reported political party (i.e., Republican as compared to all other political parties) of CMHCs and their treatment decisions about

case examples that involve politicized issues (e.g., marijuana use, abortion, gay adoption, firearms, sex reassignment)?

In this chapter, the sample demographics are discussed. Next, descriptive statistics and other statistical results are included. Quantitative analyses are then presented, the hypotheses are discussed, and lastly a summary of the chapter is provided.

Descriptive Statistics

Table 2 presents the demographic results. The survey response rate was difficult to estimate due to the inability to ascertain the exact number of AMHCA members who saw the posted invitation to participate. AMHCA staff confirmed that 1,143 members viewed the forum on the date of the original call to participate but related that they could not ascertain how many of those members saw, read, or clicked on the invitation to participate on that date as well as subsequent dates (Whitney Meyerhoeffer, personal communication, March 1, 2021). However, given that 168 AMHCA members participated in the study, the response rate can be estimated to be 14.69 % or higher. Data from 21 participants who did not answer questions about their political ideology and political party affiliation were removed, yielding a usable sample of 147 participants. Ages of participants ranged from 19 to 80 with a mean average age of 52.26 years (SD = 13.71). Forty (27.2%) of participants identified their sex as male and 107 (72.8%) participants reported their sex as female. Forty-one (27.9%) of participants identified their gender as male, 105 (71.4%) participants identified their gender as female, and 1 (0.7%) participant did not respond to the question. One hundred and twenty-five (85%) of participants identified their race as White, 12 (8.2%) self-identified as Black or African American, 3 (2%) self-identified as Asian, 6 (4.1%) self-identified as Other, and 1 (0.7%) did not answer the question. Twelve (8.2%) of participants identified their ethnicity as Hispanic or Latino, 133

(90.5 %) reported that they were not Hispanic or Latino, and 2 (1.4%) did not indicate their ethnicity. Regarding sexual orientation, 128 participants (87.1%) self-identified as heterosexual, 5 (3.4%) identified as homosexual, 10 (6.8%) identified as bisexual, 3 (2%) identified as "other," and 1 (0.7%) did not report sexual orientation. Thus, the sample was predominantly White, not Hispanic, female in both sex and gender identification, heterosexual, and middle-aged, which is consistent with national averages for counselors, as well as previous survey research (e.g., ACA, 2016b; CACREP, 2018; McBride & Hays, 2012; Norton & Tan, 2019)

With respect to religious affiliation, 50 (34%) of participants self-identified as Christian (nonspecific), 20 (13.6%) identified as Protestant, 14 (9.5%) identified as Catholic, 7 (4.8%) identified as Jewish, 1 (0.7%) identified as Mormon, 22 (15%) described their religion as "other," and 33 (22.4%) identified as having no religious affiliation.

With respect to self-described political ideology, 75 (51%) of participants identified as liberal, 29 (19.7%) identified as conservative, 11 (7.5%) identified as libertarian, 3 (2%) identified as socialist, and 29 (19.7%) described their political ideology as "other." Regarding political party registration, 69 (46.9%) reported that they were registered with the Democratic Party on their voter registration cards, 26 (17.7%) identified as Republican, 12 (8.2%) identified as Independent, 36 (24.5%) reported "no party affiliation," 1 (0.7%) participant reported an "unknown" party registration, and 3 (2%) reported that they were not registered to vote.

Participants were given the option of identifying their primary work settings as one of 12 possible counseling settings. Seventy-three (49.7%) identified their primary work setting as "self-employed/private practice," 24 (16.3%) described their primary setting as "counseling agency-private," and 50 (34%) participants identified their primary work setting as one of 9 other setting categories (see Table 2).

With respect to the number of years in practice, participants reported a range of 1 to 48 years of counseling practice with a mean average of 16.44 years (SD = 11.58). Participants were licensed in 36 states and the District of Columbia (DC). However, in comparison to other states a disproportionate number of participants reported licensure in Florida (n = 48, p = 32.7), Georgia (n = 15, p = 10.2), and Virginia (n = 11, p = 7.5).

Comparison of Means: Perception of Level of Seriousness of Clinical Problems

Prior to regression analysis, a comparison of means for perceived level of seriousness was conducted. CMHCs were asked to rank the level of seriousness of clinical problems on a scale from 1 to 10 with 1 corresponding with "not at all serious" and 10 with "very serious." Table 3 depicts the mean rankings for all 11 clinical vignettes by political ideology, and Table 4 depicts the mean rankings of all vignettes by political party registration. To determine effect size, Cohen's D (Cohen, 1992) was calculated for all mean differences and values were included in Tables 3 and 4. Though rankings of CMHCs identifying with socialist ideologies or "unknown voter registration," as well as those who are not registered to vote, are included in the table, they are not considered in the succeeding analysis due to their small group sizes.

Prediction of Level of Perceived Seriousness for Vignette #1 (Alcohol)

Clinical Vignette #1 involved a 38-year-old male who acknowledges consuming about 20 alcoholic beverages in a typical week. Conservative CMHCs ranked the level of seriousness for this vignette as .33 points (i.e., 3.3%) higher than all other CMHCs (see Table 3), and Republican CMHCs rated the level of seriousness for this vignette as only .03 points (i.e., 3%) higher than all other CMHCs. My hypotheses were that conservative and Republican CMHCs would not differ significantly from other CMHCs in perceived level of seriousness for this non-politicized issue. Given that mean differences were less than .5 points (i.e., 5%) and that the

Table 2. Demographics of Study Sample

Variable		*M*	*SD*	Min.	Max.
	Age	52.26	13.71	19	80
	Years practicing	16.44	11.58	1	48
Variable				*n*	*p*
Sex					
	Male			42	.272
	Female			107	.728
Gender					
	Male			41	.279
	Female			105	.714
	No answer			1	.007
Race					
	White			125	.850
	Black or African American			12	.082
	Asian			3	.020
	American Indian or Alaska Native			0	.000
	Native Hawaiian and Other Pacific Islander			0	.000
	Other			6	.041
	No answer			1	.007
Ethnicity					
	Hispanic or Latino			12	.082
	Non-Hispanic			133	.905
	No answer			2	.014
Sexual Orientation					
	Heterosexual			128	.871
	Homosexual			5	.034
	Bisexual			10	.068
	Other			3	.020
	No answer			1	.007
Religious Affiliation					
	Christian (nonspecific)			50	.340
	Protestant			20	.136
	Catholic			14	.095
	Jewish			7	.048
	Mormon			1	.007
	Other			22	.150
	No religious affiliation			33	.224
Political Ideology					
	Communist			0	.000
	Conservative			29	.198
	Liberal			75	.510
	Libertarian			11	.075
	Socialist			3	.002

Table 2 (Continued)

Variable		*n*	*p*
	Other	29	.197
Political Party Registration			
	Constitution Party	0	.000
	Democratic Party	69	.469
	Democratic Socialists of America	0	.000
	Green Party	0	.000
	Independent Party	12	.082
	Libertarian Party	0	.000
	Reform Party	0	.000
	Republican Party	26	.177
	Tea Party	0	.000
	No party affiliation (independent)	36	.245
	Not applicable/not registered to vote	3	.020
	Unknown	1	.007
Primary Work Setting			
	Business/industry	2	.014
	College or university	9	.061
	Correctional facility	4	.027
	Counseling agency-private	24	.163
	Government-federal	2	.014
	Government-state/county/city	8	.054
	Hospital	6	.041
	Insurance company	1	.007
	K-12 school	5	.034
	Pastoral/religious	1	.007
	Self-employed/private practice	73	.497
	Other	12	.082
State of Licensure			
	Alabama	2	.014
	Alaska	1	.007
	Arizona	3	.020
	Arkansas	2	.014
	California	0	.000
	Colorado	1	.007
	Connecticut	3	.020
	Delaware	0	.000
	District of Columbia	2	.014
	Florida	48	.327
	Georgia	15	.102
	Guam	0	.000
	Hawaii	0	.000
	Idaho	0	.000
	Illinois	2	.014
	Indiana	0	.000

Table 2 (Continued)

Variable		*n*	*p*
	Iowa	4	.027
	Kansas	1	.007
	Kentucky	0	.000
	Louisiana	0	.000
	Maine	2	.014
	Maine	1	.007
	Massachusetts	5	.034
	Michigan	3	.020
	Minnesota	0	.000
	Mississippi	1	.007
	Missouri	2	.014
	Montana	2	.014
	Nebraska	0	.000
	Nevada	0	.000
	New Hampshire	3	.020
	New Jersey	0	.000
	New Mexico	0	.000
	New York	5	.034
	North Carolina	3	.020
	North Dakota	0	.000
	Ohio	4	.027
	Oklahoma	1	.007
	Oregon	3	.020
	Pennsylvania	2	.014
	Puerto Rico	0	.000
	Rhode Island	3	.020
	South Carolina	6	.041
	South Dakota	0	.000
	Tennessee	8	.054
	Texas	4	.027
	Utah	2	.014
	Vermont	1	.007
	Virginia	11	.075
	Washington	4	.027
	West Virginia	1	.007
	Wisconsin	2	.014
	Wyoming	2	.014

effect sizes of differences between the ratings of conservative and Republican CMHCs and other CMHCs failed to reach the threshold of 0.50 generally regarded as a medium effect size (Cohen, 1992), the comparison of means supported my hypotheses.

Prediction of Level of Perceived Seriousness for Vignette #2 (Marijuana)

Clinical vignette #2 involved a 38-year-old male who uses recreational marijuana approximately three times a week. Conservative CMHCs ranked the level of seriousness for this vignette as 0.75 points (i.e., 7.5%) higher than all other CMHCs (see Table 3), and Republican CMHCs rated the level of seriousness for this vignette as 0.61 points (i.e., 6.1%) higher than all other CMHCs (see Table 4). My hypotheses were that conservative and Republican CMHCs would rate the perceived level of seriousness for this politicized issue as greater than other CMHCs. Mean differences between Republican and conservative CMHCs and all other CMHCs were greater than .5 points (i.e., 5%) with Republican and conservative CMHCs rating this politicized issue as more serious than other CMHCs. However, the effect sizes of differences between the ratings of conservative and Republican CMHCs and other CMHCs failed to reach the threshold of 0.50 generally regarded as a medium effect size (Cohen, 1992). Therefore, the comparison of means partially supported my hypotheses.

Prediction of Level of Perceived Seriousness for Vignette #3 (Tobacco)

Clinical vignette #3 involved a 38-year-old male who smokes 15-20 cigarettes per week (2-3 per day) and has been smoking since 19 years of age. Conservative CMHCs ranked the level of seriousness for this vignette as only 0.07 points (i.e., 0.7%) higher than all other CMHCs (see Table 3), and Republican CMHCs rated the level of seriousness for this vignette as 0.69 points (i.e., 6.9%) lower than all other CMHCs (see Table 4). My hypotheses were that conservative and Republican CMHCs would not differ significantly from other CMHCs in

perceived level of seriousness for this non-politicized issue. Although conservative CMHCs ranked the seriousness for this non-politicized problem as less than 0.5 points (i.e., 5%) less serious than other CMHCs, Republican CMHCs rated the problem as more than 5% less serious than other CMHCs. The effect sizes of differences between the ratings of conservative and Republican CMHCs and other CMHCs failed to reach the threshold of 0.50 generally regarded as a medium effect size (Cohen, 1992). Therefore, the comparison of means partially supported my hypothesis.

Prediction of Level of Perceived Seriousness for Vignette #4 (Sex Worker)

Clinical vignette #4 involved a 38-year-old male who reports sexual intercourse with sex workers several times in the past year. Conservative CMHCs ranked the level of seriousness for this vignette as .30 points (i.e., 3.0%) higher than all other CMHCs (see Table 3), and Republican CMHCs rated the level of seriousness for this vignette as 0.28 points (i.e., 2.8%) lower than all other CMHCs (see Table 4). My hypotheses were that conservative and Republican CMHCs would not differ significantly from other CMHCs in perceived level of seriousness for this non-politicized issue. Given that mean differences were less than .5 points (i.e., 5%) and that the effect sizes of differences between the ratings of conservative and Republican CMHCs and other CMHCs failed to reach the threshold of 0.50 generally regarded as a medium effect size (Cohen, 1992), the comparison of means supported my hypotheses.

Prediction of Level of Perceived Seriousness for Vignette #5 (Depression)

Clinical Vignette #5 involved a 38-year-old male scored a 10 on the PHQ-9, suggesting a moderate level of depressive symptoms. Conservative CMHCs ranked the level of seriousness for this vignette as 0.15 points (i.e., 1.5%) higher than all other CMHCs (see Table 3), and Republican CMHCs rated the level of seriousness for this vignette as 0.38 points (i.e., 3.8%)

higher than all other CMHCs (see Table 4). My hypotheses were that conservative and Republican CMHCs would not differ significantly from other CMHCs in perceived level of seriousness for this non-politicized issue. Given that mean differences were less than .5 points (i.e., 5%) and that the effect sizes of differences between the ratings of conservative and Republican CMHCs and other CMHCs failed to reach the threshold of 0.50 generally regarded as a medium effect size (Cohen, 1992), the comparison of means supported my hypotheses.

Prediction of Level of Perceived Seriousness for Vignette #6 (Gun Storage)

Clinical vignette #6 involved a 38-year-old male parent of two small children who acknowledges having several firearms at home. Conservative CMHCs ranked the level of seriousness for this vignette as 1.02 points (i.e., 10.2%) lower than all other CMHCs (see Table 3), and Republican CMHCs rated the level of seriousness for this vignette as 1.13 points (i.e., 11.3%) lower than all other CMHCs (see Table 4). My hypotheses were that conservative and Republican CMHCs would rate the perceived level of seriousness for this politicized issue as lower than other CMHCs. Mean differences between Republican and conservative CMHCs and all other CMHCs were greater than .5 points (i.e., 5%) with Republican and conservative CMHCs rating this politicized issue as less serious than other CMHCs. However, the effect sizes of differences between the ratings of conservative and Republican CMHCs and other CMHCs failed to reach the threshold of 0.50 generally regarded as a medium effect size (Cohen, 1992). Therefore, the comparison of means partially supported my hypotheses.

Prediction of Level of Perceived Seriousness for Vignette #7 (Obesity)

Clinical vignette #7 involved a 38-year-old male presenting with a body mass index (BMI) score of 31 indicative of obesity, acknowledging no regular exercise. Conservative CMHCs ranked the level of seriousness for this vignette as 0.11 points (i.e., 1.1%) higher than all

other CMHCs (see Table 3), and Republican CMHCs rated the level of seriousness for this vignette as 0.23 (i.e., 2.3%) points higher than all other CMHCs (see Table 4). My hypotheses were that conservative and Republican CMHCs would not differ significantly from other CMHCs in perceived level of seriousness for this non-politicized issue. Given that mean differences were less than .5 points (i.e., 5%) and that the effect sizes of differences between the ratings of conservative and Republican CMHCs and other CMHCs failed to reach the threshold of 0.50 generally regarded as a medium effect size (Cohen, 1992), the comparison of means supported my hypotheses.

Prediction of Level of Perceived Seriousness for Vignette #8 (Abortion)

Vignette #8 involved a 28-year-old female client who acknowledges having had two elective abortions in the last five years. Conservative CMHCs ranked the level of seriousness for this vignette as 1.60 points (i.e., 16%) higher than all other CMHCs (see Table 3), and Republican CMHCs rated the level of seriousness for this vignette as 0.98 points (i.e., 9.8%) higher than all other CMHCs (see Table 4). My hypotheses were that conservative and Republican CMHCs would rate the perceived level of seriousness for this politicized issue as greater than other CMHCs. Mean differences between Republican and conservative CMHCs and all other CMHCs were greater than .5 points (i.e., 5%) with Republican and conservative CMHCs rating this politicized issue as more serious than other CMHCs. The effect size of mean differences between the ratings of conservative and other CMHCs was 0.61, but the effect size of mean differences between Republican CMHCs and other CMHCs failed to reach the threshold of 0.50 generally regarded as a medium effect size (Cohen, 1992). Therefore, the comparison of means partially supported my hypotheses.

Prediction of Level of Perceived Seriousness for Vignette #9 (Lesbian Adoption)

Clinical vignette #10 involved a lesbian couple in their 30s reporting that they are married wish to adopt a child but want to address some disagreements about childrearing practices before going forward with adoption. Conservative CMHCs ranked the level of seriousness for this vignette as 0.49 points (i.e., 4.9%) higher than all other CMHCs (see Table 3), and Republican CMHCs rated the level of seriousness for this vignette as 0.75 (i.e., 7.5%) higher than all other CMHCs (see Table 4). My hypotheses were that conservative and Republican CMHCs would rate the level of seriousness for this politicized issue as greater than other CMHCs. Mean differences in perceived level of seriousness were greater than .5 points (i.e., 5%) between the ratings of conservative and Republican CMHCs and other CMHCs but failed to reach the threshold of 0.50 generally regarded as a medium effect size (Cohen, 1992), Therefore, the comparison of means partially supported my hypotheses.

Prediction of Level of Perceived Seriousness for Vignette #10 (Emotional Support Animal)

Vignette #10 involved a 38-year-old male requesting an emotional support animal (ESA) letter so that his dog can accompany him on planes to alleviate depression and generalized anxiety. Conservative CMHCs ranked the level of seriousness for this vignette as 0.78 points (i.e., 7.8%) higher than all other CMHCs (see Table 3), and Republican CMHCs rated the level of seriousness for this vignette as 0.08 (i.e., 0.8%) higher than all other CMHCs (see Table 4). My hypotheses were that conservative and Republican CMHCs would not differ significantly from other CMHCs in perceived level of seriousness for this non-politicized issue. The mean difference for conservative and other CMHCs was greater than .05 (i.e., 5%) points, but the mean difference between Republican and other CMHCs was not. The effect size for mean differences between both conservative and other CMHCS and for Republican and other CMHCs was less

than the threshold of 0.50 generally regarded as a medium effect size (Cohen, 1992). Therefore, the comparison of means partially supported my hypotheses.

Prediction of Level of Perceived Seriousness for Vignette #11 (Gender Dysphoria)

Clinical vignette #11 involved a 25-year-old male client who identifies as transgender, is transitioning from female to male, and is requesting a letter attesting to his Gender Dysphoria so that he can proceed with a double mastectomy. Conservative CMHCs ranked the level of seriousness for this vignette as 1.07 points (i.e., 10.7%) lower than all other CMHCs (see Table 3), and Republican CMHCs rated the level of seriousness for this vignette as 0.58 (i.e., 5.8%) lower than all other CMHCs (see Table 4). My hypotheses were that conservative and Republican CMHCs would rate the seriousness of this clinical problem as higher than other CMHCs for this politicized issue. Mean differences between Republican and conservative CMHCs and all other CMHCs were greater than .5 points (i.e., 5%) with Republican and conservative CMHCs rating this politicized issue as more serious than other CMHCs. The effect size for the mean differencs between conservative and other CMHCs reached the threshold of 0.50 generally regarded as a medium effect size (Cohen, 1992), but the effect size for the mean difference between Republican and other CMHCs did not. Therefore, the comparison of means partially supported my hypotheses.

Table 3. Comparison of Mean Level of Perceived Seriousness of Clinical Problems by CMHC Political Ideology

Problem	Hypothesis	Mean	Political Ideology						Effect Size				
			Conservative (1)	Liberal (2)	Libertarian (3)	Socialist (4)	Other (5)	NC* (6)	1 vs 2	1 vs 3	1 vs 4	1 vs 5	1 vs 6
Alcohol	no differences	*n*	28	70	11	3	28	118	0.00	0.59	N/A**	0.37	0.18
		M	7.64	7.64	6.45	7	6.86	7.31					
		SD	2.02	1.63	2.02	1.73	2.17	1.85					
Marijuana	conservatives perceive greater seriousness	*n*	27	68	11	3	28	109	0.36	0.11	N/A	0.17	0.30
		M	5.67	4.79	5.36	3.33	5.22	4.92					
		SD	2.84	2.32	2.54	3.22	2.36	2.36					
Tobacco	no differences	*n*	27	69	10	3	26	108	0.02	0.11	N/A	0.17	0.03
		M	6.22	6.17	6.50	7.67	5.77	6.15					
		SD	2.65	2.56	2.41	4.04	2.69	2.60					
Sex Worker	no differences	*n*	27	69	11	3	26	109	0.57	0.04	N/A	0.30	0.14
		M	7.63	6.17	7.73	7.00	6.92	7.33					
		SD	2.54	2.56	1.60	1.00	2.17	2.06					
Depression	no differences	*n*	27	68	11	3	26	108	0.13	0.12	N/A	0.08	0.11
		M	7.93	7.74	7.73	8.67	7.81	7.78					
		SD	1.80	1.27	1.35	1.16	1.23	1.26					
Gun Storage	conservatives perceive less seriousness	*n*	27	68	11	3	26	108	0.64	0.26	N/A	0.29	0.38
		M	5.70	7.26	4.91	2.67	6.54	6.72					
		SD	2.97	2.20	3.18	1.53	2.83	2.62					
Obesity	no differences	*n*	27	65	11	3	26	105	0.01	0.18	N/A	0.06	0.05
		M	7.00	6.98	6.64	5.67	6.88	6.89					
		SD	1.94	1.96	2.29	4.04	1.95	2.04					

Table 3 (Continued)

Problem	Hypothesis	Mean	Political Ideology						Effect Size				
			Conservative (1)	Liberal (2)	Libertarian (3)	Socialist (4)	Other (5)	NC* (6)	1 vs 2	1 vs 3	1 vs 4	1 vs 5	1 vs 6
Abortion	conservatives perceive greater seriousness	*n*	27	66	10	3	26	105	0.69	0.05	N/A	0.58	0.61
		M	6.48	4.73	6.60	1.67	4.96	4.88					
		SD	2.47	2.58	2.27	1.16	2.74	2.64					
Lesbian Adoption	conservatives perceive greater seriousness	*n*	27	68	11	3	26	108	0.27	0.10	N/A	0.04	0.21
		M	5.78	5.13	5.55	4.33	5.69	5.29					
		SD	2.15	2.45	2.70	1.53	2.09	2.36					
Emotional Support Animal	no differences	*n*	26	68	10	2	26	106	0.52	0.41	N/A	0.01	0.35
		M	5.65	4.54	4.70	7.00	5.62	4.87					
		SD	2.31	2.07	2.41	4.24	2.23	2.21					
Gender Dysphoria	conservatives perceive greater seriousness	*n*	26	68	10	3	26	107	0.56	0.14	N/A	0.55	0.50
		M	7.23	8.41	7.60	6.67	8.46	8.30					
		SD	2.64	1.87	2.46	4.16	1.75	1.98					

* Effect sizes comparing socialists to conservatives were not calculated due to the small sample size of socialists.
** NC = all groups other than conservatives

Table 4. Comparison of Mean Level of Perceived Seriousness of Clinical Problems by CMHC Political Party Registration

Problem	Hypothesis	Mean	Political Party Registration							Effect Size					
			Rep. (1)	Dem. (2)	Ind. (3)	NPA (4)	NR* (5)	Unk. (6)	NRep** (7)	1 vs 2	1 vs 3	1 vs 4	1 vs 5	1 vs 6	1 vs 7
Alcohol	no differences	*n*	25	64	12	35	3	1	115	0.03	0.20	0.05	N/A***	N/A	0.02
		M	7.40	7.45	7.00	7.49	6.67	5.00	7.37						
		SD	2.04	1.94	1.86	1.70	2.31	--	1.86						
Marijuana	Republicans perceive greater seriousness	*n*	25	61	12	34	3	1	111	0.27	0.27	0.13	N/A	N/A	0.25
		M	5.56	4.85	4.83	5.24	6.67	5.00	4.95						
		SD	2.83	2.54	2.48	2.22	2.31	--	2.38						
Tobacco	no differences	*n*	25	61	12	34	3	--	110	0.27	0.27	0.37	N/A	N/A	0.27
		M	5.60	6.33	5.58	6.59	5.00	--	6.29						
		SD	2.81	2.60	2.56	2.54	1.00	--	2.55						
Sex Worker	no differences	*n*	25	60	12	35	3	1	111	0.20	0.01	0.06	N/A	N/A	0.13
		M	7.16	7.62	7.25	7.31	7.00	5.00	7.44						
		SD	2.73	2.03	2.30	2.00	1.0	--	2.02						
Depression	no differences	*n*	25	59	12	35	3	1	110	0.24	0.03	0.34	N/A	N/A	0.19
		M	8.12	7.76	8.08	7.63	7.33	7.00	7.74						
		SD	1.72	1.41	1.17	1.17	0358	--	1.28						
Gun Storage	Republicans perceive less seriousness	*n*	25	59	12	35	3	1	110	0.55	0.05	0.23	N/A	N/A	0.42
		M	5.60	7.12	5.75	6.23	7.67	10.0	6.73						
		SD	3.10	2.59	2.86	2.40	2.52	--	2.59						
Obesity	no differences	*n*	25	56	12	35	3	1	107	0.30	0.24	0.00	N/A	N/A	0.11
		M	6.72	7.29	6.17	6.71	6.67	7.00	6.95						
		SD	2.11	1.80	2.66	2.09	1.16	--	2.00						

Table 4 (Continued)

Problem	Hypothesis	Mean	Political Party Registration							Effect Size					
			Rep. (1)	Dem. (2)	Ind. (3)	NPA (4)	NR* (5)	Unk. (6)	NRep** (7)	1 vs 2	1 vs 3	1 vs 4	1 vs 5	1 vs 6	1 vs 7
Abortion	Republicans perceive greater seriousness	*n*	25	57	12	34	3	1	107	0.34	0.65	0.31	N/A	N/A	0.37
		M	6.00	5.09	4.42	5.24	2.67	8.00	5.02						
		SD	2.48	2.82	2.30	2.45	1.16	--	2.71						
Lesbian Adoption	Republicans perceive greater seriousness	*n*	25	58	12	35	3	1	110	0.21	0.86	0.32	N/A	N/A	0.32
		M	6.00	5.54	4.08	5.29	2.67	8.00	5.25						
		SD	2.06	2.28	2.58	2.28	0.58	--	2.37						
Emotional Support Animal	no differences	*n*	23	58	12	35	3	1	109	0.04	0.33	0.04	N/A	N/A	0.04
		M	5.09	5.00	4.25	5.17	5.33	8.00	5.01						
		SD	2.47	2.28	2.76	1.92	1.53	--	2.21						
Gender Dysphoria	Republicans perceive greater seriousness	*n*	23	59	12	35	3	1	110	0.37	0.05	0.13	N/A	N/A	0.27
		M	7.61	8.47	7.75	7.91	7.67	8.00	8.19						
		SD	2.74	1.75	2.93	2.08	2.51	--	2.01						

* Denotes participants who reported that they were not registered to vote.
** Denotes participants who are not registered as Republicans
*** Effect sizes comparing participants who reported they were not registered to vote and those with unknown party registration were not calculated due to the small sample size of socialists.

Comparison of Means: Treatment Decisions

Prior to regression analysis, a comparison of means for treatment decisions was conducted. CMHCs were asked to rank the likelihood of various clinical interventions for each clinical vignette on a scale from 1 to 10 with 1 corresponding with "definitely would not" and 10 with "definitely would." As described in Chapter 3, treatment decision options for each vignette were combined into one treatment decision scale per vignette. Table 5 depicts the mean treatment decision scale scores for all 11 clinical vignettes by political ideology, and Table 6 depicts the mean treatment decision scales scores for all vignettes by political party registration. To determine effect size, Cohen's D (Cohen, 1992) was calculated for all mean differences and values were included in Tables 5 and 6.

Treatment Decisions for Vignette #1 (Alcohol)

Clinical Vignette #1 involved a 38-year-old male who acknowledges consuming about 20 alcoholic beverages in a typical week. The mean treatment decision score of conservative CMHCs was 0.21 points (i.e., 2.1%) higher than all other CMHCs (see Table 5), and the mean treatment decision score of Republican CMHCs was 0.93 points (i.e., 9.3%) lower than all other CMHCs (see Table 6). My hypotheses were that conservative and Republican CMHCs would not differ significantly from other CMHCs in treatment decision scale scores for this non-politicized issue. Given that the mean difference between conservative and other CMHCs was less than .5 points (i.e., 5%) but greater than .5 points for Republican as compared to other CMHCs, and that the effect sizes of differences between the ratings of conservative and Republican CMHCs and other CMHCs failed to reach the threshold of 0.50 generally regarded as a medium effect size (Cohen, 1992), the comparison of means partially supported my hypotheses.

Treatment Decisions for Vignette #2 (Marijuana)

Clinical vignette #2 involved a 38-year-old male who uses recreational marijuana approximately three times a week. The mean treatment decision score of conservative CMHCs was 0.16 points (i.e., 1.6%) lower than all other CMHCs (see Table 5), and the mean treatment decision score of Republican CMHCs was 0.51 points (i.e., 5.1%) lower than all other CMHCs (see Table 6). My hypotheses were that conservative and Republican CMHCs would differ significantly from other CMHCs in treatment decision scale scores for this politicized issue. Given that the mean difference between conservative and other CMHCs was less than .5 points (i.e., 5%) but greater than .5 points for Republican as compared to other CMHCs, and that the effect sizes of differences between the ratings of conservative and Republican CMHCs and other CMHCs failed to reach the threshold of 0.50 generally regarded as a medium effect size (Cohen, 1992), the comparison of means partially supported my hypotheses.

Treatment Decisions for Vignette #3 (Tobacco)

Clinical vignette #3 involved a 38-year-old male who smokes 15-20 cigarettes per week (2-3 per day) and has been smoking since 19 years of age. The mean treatment decision score of conservative CMHCs was 0.43 points (i.e., 4.3%) lower than all other CMHCs (see Table 5), and the mean treatment decision score of Republican CMHCs was 1.24 points (i.e., 12.4%) lower than all other CMHCs (see Table 6). My hypotheses were that conservative and Republican CMHCs would not differ significantly from other CMHCs in treatment decision scale scores for this non-politicized issue. The mean difference between conservative and other CMHCs was less than .5 points (i.e., 5%) but greater than .5 points for Republican as compared to other CMHCs. The effect size of differences between the ratings of conservative and other CMHCs failed to reach the threshold of 0.50 generally regarded as a medium effect size (Cohen, 1992),

whereas the effect size for the difference in mean score between Republican and other CMHCs was medium. The comparison of means therefore partially supported my hypotheses.

Treatment Decisions for Vignette #4 (Sex Worker)

Clinical vignette #4 involved a 38-year-old male who reports sexual intercourse with sex workers several times in the past year. The mean treatment decision score of conservative CMHCs was 0.03 points (i.e., 0.3%) higher than all other CMHCs (see Table 5), and the mean treatment decision score of Republican CMHCs was 0.56 points (i.e., 5.6%) lower than all other CMHCs (see Table 6). My hypotheses were that conservative and Republican CMHCs would not differ significantly from other CMHCs in treatment decision scale scores for this non-politicized issue. Given that the mean difference between conservative and other CMHCs was less than .5 points (i.e., 5%) but greater than .5 points for Republican as compared to other CMHCs, and that the effect sizes of differences between the ratings of conservative and Republican CMHCs and other CMHCs failed to reach the threshold of 0.50 generally regarded as a medium effect size (Cohen, 1992), the comparison of means partially supported my hypotheses.

Treatment Decisions for Vignette #5 (Depression)

Clinical Vignette #5 involved a 38-year-old male scored a 10 on the PHQ-9, suggesting a moderate level of depressive symptoms. The mean treatment decision score of conservative CMHCs was 0.37 points (i.e., 3.7%) higher than all other CMHCs (see Table 5), and the mean treatment decision score of Republican CMHCs was 0.40 points (i.e., 4.1%) higher than all other CMHCs (see Table 6). My hypotheses were that conservative and Republican CMHCs would not differ significantly from other CMHCs in treatment decision scale scores for this non-politicized issue. Given that mean differences between conservative and Republican CMHCs

and other CMHCs were less than .5 points (i.e., 5%), and that the effect sizes of differences between the ratings of conservative and Republican CMHCs and other CMHCs failed to reach the threshold of 0.50 generally regarded as a medium effect size (Cohen, 1992), the comparison of means supported my hypotheses.

Treatment Decisions for Vignette #6 (Gun Storage)

Clinical vignette #6 involved a 38-year-old male parent of two small children who acknowledges having several firearms at home. The mean treatment decision score of conservative CMHCs was 0.55 points (i.e., 5.5%) lower than all other CMHCs (see Table 5), and the mean treatment decision score of Republican CMHCs was 1.16 points (i.e., 11.6%) lower than all other CMHCs (see Table 6). My hypotheses were that conservative and Republican CMHCs would differ significantly from other CMHCs in treatment decision scale scores for this politicized issue. The mean difference between conservative and Republican CMHCs as compared to other CMHCs was greater than .5 points (i.e., 5%). The effect size of differences between the ratings of Republican CMHCs and other CMHCs reached the threshold of 0.50 generally regarded as a medium effect size (Cohen, 1992). However, the effect size for the difference between conservative and other CMHCs did not. Therefore, the comparison of means partially supported my hypotheses.

Treatment Decisions for Vignette #7 (Obesity)

Clinical vignette #7 involved a 38-year-old male presenting with a body mass index (BMI) score of 31 indicative of obesity, acknowledging no regular exercise. The mean treatment decision score of conservative CMHCs was 0.07 points (i.e., 0.7%) lower than all other CMHCs (see Table 5), and the mean treatment decision score of Republican CMHCs was 0.44 points (i.e., 4.4%) lower than all other CMHCs (see Table 6). My hypotheses were that conservative

and Republican CMHCs would not differ significantly from other CMHCs in treatment decision scale scores for this non-politicized issue. Given that the mean difference between conservative and Republican CMHCs and all other CMHCs was less than .5 points (i.e., 5%), and that the effect sizes of differences between the ratings of conservative and Republican CMHCs and other CMHCs failed to reach the threshold of 0.50 generally regarded as a medium effect size (Cohen, 1992), the comparison of means supported my hypotheses.

Treatment Decisions for Vignette #8 (Abortion)

Vignette #8 involved a 28-year-old female client who acknowledges having had two elective abortions in the last five years. The mean treatment decision score of conservative CMHCs was 0.57 points (i.e., 5.7%) higher than all other CMHCs (see Table 5), and the mean treatment decision score of Republican CMHCs was 0.01 points (i.e., 0.1%) lower than all other CMHCs (see Table 6). My hypotheses were that conservative and Republican CMHCs would differ significantly from other CMHCs in treatment decision scale scores for this politicized issue. Given that the mean difference between conservative and other CMHCs was greater than .05 points (i.e., 5%), but the difference between Republican and other CMHCs was not. The effect sizes of differences between the ratings of conservative and Republican CMHCs and other CMHCs failed to reach the threshold of 0.50 generally regarded as a medium effect size (Cohen, 1992), the comparison of means partially supported my hypotheses.

Treatment Decisions for Vignette #9 (Lesbian Adoption)

Clinical vignette #10 involved a lesbian couple in their 30s reporting that they are married wish to adopt a child but want to address some disagreements about childrearing practices before going forward with adoption. The mean treatment decision score of conservative CMHCs was 0.23 points (i.e., 2.3%) higher than all other CMHCs (see Table 5),

and the mean treatment decision score of Republican CMHCs was 0.09 points (i.e., 0.9%) higher than all other CMHCs (see Table 6). My hypotheses were that conservative and Republican CMHCs would differ significantly from other CMHCs in treatment decision scale scores for this politicized issue. Given that the mean difference between conservative and Republican CMHCs as compared to other CMHCs was less than .5 points (i.e., 5%), and that the effect sizes of differences between the ratings of conservative and Republican CMHCs and other CMHCs failed to reach the threshold of 0.50 generally regarded as a medium effect size (Cohen, 1992), the comparison of means did not support my hypotheses.

Treatment Decisions for Vignette #10 (Emotional Support Animal)

Vignette #10 involved a 38-year-old male requesting an emotional support animal (ESA) letter so that his dog can accompany him on planes to alleviate depression and generalized anxiety. The mean treatment decision score of conservative CMHCs was 0.54 points (i.e., 5.4%) lower than all other CMHCs (see Table 5), and the mean treatment decision score of Republican CMHCs was 0.48 points (i.e., 4.8%) lower than all other CMHCs (see Table 6). My hypotheses were that conservative and Republican CMHCs would not differ significantly from other CMHCs in treatment decision scale scores for this non-politicized issue. Given that the mean difference between conservative and Republican CMHCs and other CMHCs was near or above .5 points (i.e., 5%) but that the effect sizes of differences between the ratings of conservative and Republican CMHCs and other CMHCs failed to reach the threshold of 0.50 generally regarded as a medium effect size (Cohen, 1992), the comparison of means partially supported my hypotheses.

Treatment Decisions for Vignette #11 (Gender Dysphoria)

Clinical vignette #11 involved a 25-year-old male client who identifies as transgender, is transitioning from female to male, and is requesting a letter attesting to his Gender Dysphoria so that he can proceed with a double mastectomy. The mean treatment decision score of conservative CMHCs was 1.11 points (i.e., 11.1%) lower than all other CMHCs (see Table 5), and the mean treatment decision score of Republican CMHCs was 1.41 points (i.e., 14.1%) lower than all other CMHCs (see Table 6). My hypotheses were that conservative and Republican CMHCs would differ significantly from other CMHCs in treatment decision scale scores for this politicized issue. Given that the mean difference between conservative and Republican CMHCs and other CMHCs was above .5 points (i.e., 5%) and that the effect sizes of differences between the ratings of conservative and Republican CMHCs and other CMHCs were near or above the threshold of 0.50 generally regarded as a medium effect size (Cohen, 1992), the comparison of means supported my hypotheses.

Multiple Regression for Research Question #1

Research Question #1 sought to identify the relationship between CMHCs' reported political ideology (i.e., conservative ideology compared to all other political ideologies) and their perceived levels of seriousness of problems related to politicized issues (i.e., marijuana use, abortion, gay adoption, firearms, sex reassignment). My hypothesis for research question #1 was that there would be a statistically significant difference between conservative and other CMHCs and perceived levels of seriousness of clinical problems for politicized issues.

A multiple linear regression was conducted for each of the 11 clinical vignettes comparing Model 1(i.e., demographic variables consisting of age, gender, race, ethnicity, religious affiliation) and Model 2, which added political ideology. For the six non-politicized

Table 5. Comparison of Treatment Decision Scale Scores by CMHC Political Ideology

Problem	Hypothesis	Mean	Political Ideology		Effect Size
			Conservative	Non-Conservative	
Alcohol	no differences	*n*	28	111	0.09
		M	6.69	6.48	
		SD	2.61	2.12	
Marijuana	differences	*n*	27	109	0.06
		M	5.79	5.95	
		SD	2.77	2.45	
Tobacco	no differences	*n*	27	108	0.17
		M	5.66	6.09	
		SD	2.86	2.47	
Sex Worker	no differences	*n*	27	109	0.02
		M	7.66	7.63	
		SD	2.29	1.85	
Depression	no differences	*n*	27	109	0.32
		M	8.59	8.22	
		SD	1.25	1.12	
Gun Storage	differences	*n*	27	108	0.26
		M	6.67	7.22	
		SD	2.23	2.07	
Obesity	no differences	*n*	26	104	0.03
		M	6.69	6.76	
		SD	2.18	2.17	
Abortion	differences	*n*	27	105	0.26
		M	5.98	5.41	
		SD	2.41	2.14	
Lesbian Adoption	differences	*n*	27	108	0.18
		M	7.23	7.00	
		SD	1.64	1.22	
Emotional Support Animal	no differences	*n*	26	107	0.34
		M	6.60	7.14	
		SD	2.22	1.42	
Gender Dysphoria	differences	*n*	26	105	0.47
		M	4.68	5.79	
		SD	2.46	2.36	

Table 6. Comparison of Treatment Decision Scale Scores by CMHC Political Party

Problem	Hypothesis	Mean	Political Party		Effect Size
			Republican	Non-Republican	
Alcohol	no differences	*n*	25	114	0.42
		M	5.76	6.69	
		SD	2.52	2.13	
Marijuana	differences	*n*	25	111	0.20
		M	5.50	6.01	
		SD	2.47	2.52	
Tobacco	no differences	*n*	25	110	0.49
		M	5.00	6.24	
		SD	2.62	2.49	
Sex Worker	no differences	*n*	25	111	0.29
		M	7.18	7.74	
		SD	2.52	1.77	
Depression	no differences	*n*	25	111	0.35
		M	8.62	8.22	
		SD	1.12	1.15	
Gun Storage	differences	*n*	25	110	0.56
		M	6.16	7.32	
		SD	2.31	2.00	
Obesity	no differences	*n*	24	106	0.20
		M	6.39	6.83	
		SD	2.33	2.13	
Abortion	differences	*n*	25	107	0.00
		M	5.52	5.53	
		SD	2.38	2.16	
Lesbian Adoption	differences	*n*	25	110	0.07
		M	7.12	7.03	
		SD	1.64	1.24	
Emotional Support Animal	no differences	*n*	23	110	0.30
		M	6.64	7.12	
		SD	2.17	1.47	
Gender Dysphoria	differences	*n*	23	108	0.60
		M	4.41	5.82	
		SD	2.69	2.29	

issues, no differences between Model 1 and Model 2 reached the threshold of statistical significance at a confidence level of 95% or higher (see Table 7). Of the five politicized issues (i.e., marijuana use, abortion, gay adoption, firearms, sex reassignment), two yielded statistically significant differences, including gun storage ($F(10,119) = 2.66$, $p = .006$, $R^2 = .183$, $R^2_{\text{Adjusted}} = .114$) and abortion ($F(10,116) = 2.01$, $p = .038$, $R^2 = .148$, $R^2_{\text{Adjusted}} = .074$). In addition to conservative political ideology ($\beta = -2.18$, $t(129) = -2.318$, $p = .022$), age ($\beta = -.052$, $t(129) = 2.895$, $p = .005$), female gender ($\beta = .191$, $t(129) = 2.210$, $p = .029$), and Black race ($\beta = .212$, $t(129) = 2.406$, $p = .018$), when utilizing White race as a reference point, predicted perceived level of seriousness for the gun storage vignette. In addition to conservative political ideology ($\beta = .211$, $t(126) = 2.170$, $p = .032$), age ($\beta = .229$, $t(126) = 2.459$, $p = .015$) predicted level of perceived level of seriousness for the abortion vignette. Given that conservative political ideology predicted level of perceived seriousness for only two of five politicized issues, results only partially supported hypothesis #1.

Multiple Regression for Research Question #2

Research Question #2 sought to identify the relationship between CMHCs' reported political party registration (i.e., Republican as compared to all other political parties) and their perceived levels of seriousness of problems related to politicized issues (i.e., marijuana use, abortion, gay adoption, firearms, sex reassignment). My hypothesis for research question #2 was that there would be a statistically significant difference between Republican and other CMHCs and perceived levels of seriousness of clinical problems for politicized issues.

A multiple linear regression was conducted for each of the 11 clinical vignettes comparing Model 1(i.e., demographic variables consisting of age, gender, race, ethnicity, religious affiliation) and Model 2, which added political party registration. For all 11 clinical

vignettes, no differences between Model 1 and Model 2 reached the threshold of statistical significance at a confidence level of 95% or higher (see Table 7). Therefore, the data did not support my hypothesis for research question #2.

Multiple Regression for Research Question #3

Research Question #3 sought to identify the relationship between the reported political ideology (i.e., conservative compared to all other political ideologies) of CMHCs and their treatment decisions about case examples that involve politicized issues (i.e., marijuana use, abortion, gay adoption, firearms, sex reassignment)? My hypothesis for research question #3 was that there would be a statistically significant difference between conservative and other CMHCs and their treatment decisions about case examples that involve politicized issues (i.e., marijuana use, abortion, gay adoption, firearms, sex reassignment).

A multiple linear regression was conducted for each of the 11 clinical vignettes comparing Model 1 (i.e., demographic variables consisting of age, gender, race, ethnicity, religious affiliation) and Model 2, which added political ideology. The dependent variable was identified as CMHCs' scores on treatment decision scales for each vignette. For all 11 clinical vignettes, no differences between Model 1 and Model 2 reached the threshold of statistical significance at a confidence level of 95% or higher (see Table 8). Therefore, the data did not support my hypothesis for research question #3.

Multiple Regression for Research Question #4

Research Question #4 sought to identify the relationship between the reported political party (i.e., Republican as compared to all other political parties) of CMHCs and their treatment decisions about case examples that involve politicized issues (i.e., marijuana use, abortion, gay adoption, firearms, sex reassignment)? My hypothesis for research question #4 was that there

would be a statistically significant difference between Republican and other CMHCs and their treatment decisions about case examples that involve politicized issues (i.e., marijuana use, abortion, gay adoption, firearms, sex reassignment).

A multiple linear regression was conducted for each of the 11 clinical vignettes comparing Model 1 (i.e., demographic variables consisting of age, gender, race, ethnicity, religious affiliation) and Model 2, which added political party. The dependent variable was identified as CMHCs' scores on treatment decision scales for each vignette. For five of the six non-politicized issues, no differences between Model 1 and Model 2 reached the threshold of statistical significance at a confidence level of 95% or higher (see Table 8). For the remaining non-politicized issue (i.e., tobacco use), the analysis yielded a statistically significant difference between Republican and other CMHCs ($F(10,129) = 1.91$, $p = .05$, $R^2 = .138$, $R^2_{\text{Adjusted}} = .066$). In addition to Republican Party registration ($\beta = -.203$, $t(129) = -2.218$, $p = .028$), other race (i.e., Asian, American Indian or Alaska Native, Native Hawaiian and Other Pacific Islander, other race) ($\beta = -.269$, $t(129) = -2.914$, $p = .004$), when utilizing White race as a reference point, predicted scores on the treatment decision scale for the tobacco use vignette. Of five politicized issues, a statistically significant difference was obtained for the gun storage vignette only ($F(10,129) = 2.948$, $p = .002$, $R^2 = .199$, $R^2_{\text{Adjusted}} = .131$). In addition to Republican Party registration ($\beta = -.186$, $t(129) = -2.115$, $p = .037$), female gender ($\beta = .204$, $t(129) = 2.404$, $p = .018$), other race (i.e., Asian, American Indian or Alaska Native, Native Hawaiian and Other Pacific Islander, other race) ($\beta = -.279$, $t(129) = -3.135$, $p = .002$) when using White race as a reference point, and Hispanic ethnicity ($\beta = -.190$, $t(129) = 2.111$, $p = .037$) predicted scores on the treatment decision scale for the gun storage vignette. Therefore, the data only partially supported my hypothesis for research question #4.

Table 7. R^2 Values for Level of Seriousness of Clinical Problems by Political Ideology and Political Party Registration

Scenario	Political Ideology			Party Registration		
	Model 1*	Model 2**	Significance***	Model 1*	Model 2**	Significance***
Alcohol	.040	.042	.632	.040	.040	.894
Marijuana	.054	.057	.502	.054	.056	.607
Tobacco	.110	.110	.835	.110	.123	.183
Sex Worker	.066	.066	.993	.066	.068	.603
Depression	.033	.034	.738	.033	.041	.321
Gun Storage	.146	.183	**.022**	.146	.160	.164
Obesity	.132	.132	.910	.132	.139	.332
Abortion	.113	.148	**.032**	.113	.130	.133
Lesbian Adoption	.196	.203	.325	.196	.209	.173
Emotional Support Animal	.113	.128	.157	.113	.113	.993
Gender Dysphoria	.090	.113	.083	.090	.100	.258

** Model 1 includes demographic variables (i.e., age, gender, race, ethnicity, religious affiliation)*
*** Model 2 includes demographic variables and political ideology or political party registration*
**** Significance of Model 2*

Table 8

R^2 Values for Treatment Decision Scales by Political Ideology and Political Party Registration

Scenario	Political Ideology			Party Registration		
	Model 1*	Model 2**	Significance	Model 1*	Model 2**	Significance***
Alcohol	.147	.148	.729	.147	.164	.111
Marijuana	.078	.085	.344	.078	.084	.389
Tobacco	.103	.116	.147	.103	.138	**.028**
Sex Worker	.135	.138	.535	.135	.144	.269
Depression	.112	.117	.410	.112	.126	.170
Gun Storage	.168	.192	.067	.168	.199	**.037**
Obesity	.140	.145	.399	.140	.144	.436
Abortion	.108	.113	.429	.108	.109	.846
Lesbian Adoption	.094	.094	.977	.094	.095	.722
ESA	.185	.185	.909	.185	.185	.991
Gender Dysphoria	.221	.227	.333	.221	.237	.116

** Model 1 includes demographic variables (i.e., age, gender, race, ethnicity, religious affiliation)*
*** Model 2 includes demographic variables and political ideology or political party registration*
**** Significance of Model 2*

Summary

Descriptive statistics were analyzed, and quantitative data was measured through comparison of means and multiple regression analyses. Findings from this study are summarized in Table 9. Overall, two statistically significant differences between conservative and other CMHCs (i.e., perceived level of seriousness of gun storage and abortion vignettes) and two statistically significant differences between Republican and other CMHCs (i.e., treatment decisions for tobacco and gun storage vignettes) were noted for a total of four significant differences. Thus, research hypotheses 1 and 4 were partially supported. Chapter 5 will discuss these findings as well as limitations of the study, suggestions for future research, implications for the clinical mental health counseling profession, and final conclusions.

Table 9. Research Findings

Research Question	Findings
1. What is the relationship between CMHCs' reported political ideology (i.e., conservative as compared to all other political ideologies) and their perceived levels of seriousness of problems related to politicized issues (i.e., marijuana use, abortion, gay adoption, firearms, sex reassignment)?	• On a 10-point scale of perceived level of seriousness, the mean score of conservative CMHCs was at least .5 points *higher* than other CMHCs for vignettes involving marijuana use, abortion, lesbian adoption, and an emotional support animal, though effect size was small for all vignettes except abortion, for which there was a medium effect size. • On a 10-point scale of perceived level of seriousness, the mean score of conservative CMHCs was at least .5 points *lower* than other CMHCs for vignettes involving gun storage and gender dysphoria with a small effect size for gun storage but a medium effect size for gender dysphoria. • After controlling for age, gender, race, ethnicity, and religious affiliation, there was a statistically significant relationship between conservative political ideology and the perceived level of seriousness for vignettes involving gun storage and abortion.
2. What is the relationship between the reported political party (i.e., Republican as compared to all other political parties) of CMHCs and their perceived levels of seriousness of problems related to politicized issues (i.e., marijuana use, abortion, gay adoption, firearms, sex reassignment)?	• On a 10-point scale of perceived level of seriousness, the mean score of Republican CMHCs was at least .5 points *higher* than other CMHCs for vignettes involving marijuana use, tobacco use, abortion, and lesbian adoption, though effect size was small for all vignettes. • On a 10-point scale of perceived level of seriousness, the mean score of Republican CMHCs was at least .5 points *lower* than other CMHCs for the vignettes involving alcohol, tobacco, gun storage, and gender dysphoria, though effect sizes were small. • After controlling for age, gender, race, ethnicity, and religious affiliation, there was no statistically significant relationship between conservative political ideology and the perceived level of seriousness of any clinical vignette.

Table 9 (Continued)

3. What is the relationship between the reported political ideology (i.e., conservative as compared to all other political ideologies) of CMHCs and their treatment decisions about case examples that involve politicized issues (i.e., marijuana use, abortion, gay adoption, firearms, sex reassignment)?	• On a 10-point treatment decision scale, the mean score of conservative CMHCs was at least .5 points *higher* than other CMHCs for the vignette involving abortion, though effect size was small. • On a 10-point treatment decision scale, the mean score of conservative CMHCs was at least .5 points *lower* than other CMHCs for the vignettes involving gun storage, an emotional support animal, and gender dysphoria with small effect sizes (though the effect size for gender dysphoria was near the medium threshold) • After controlling for age, gender, race, ethnicity, and religious affiliation, there was no statistically significant relationship between conservative political ideology and the scores on treatment decision scales for each clinical vignette.
4. What is the relationship between the reported political party (i.e., Republican as compared to all other political parties) of CMHCs and their treatment decisions about case examples that involve politicized issues (i.e., marijuana use, abortion, gay adoption, firearms, sex reassignment)?	• On a 10-point treatment decision scale, the mean score of Republican CMHCs was at least .5 points *lower* than other CMHCs for the vignettes involving tobacco, marijuana, sex workers, gun storage, an emotional support animal, and gender dysphoria. Effect sizes were small for marijuana, sex workers, and an emotional support animal but medium for tobacco, gun storage, and gender dysphoria. • After controlling for age, gender, race, ethnicity, and religious affiliation, there was a statistically significant relationship between Republican Party registration and the scores on treatment decision scales for the tobacco and gun storage vignettes. The tobacco vignette was not conceptualized as a politicized issue, whereas the gun storage vignette was.

Chapter 5: Discussion

Peer-reviewed literature (e.g., Dorre & Kinnier, 2006; Pietrofesa & Schlossberg, 1970; Strohmer & Shivy, 1994) and graduate-level textbooks (e.g., Corey, 2013; Erford, 2015; Gladding & Newsome, 2018; Murdock, 2017) in the field of mental health counseling have stressed the importance of recognition of counselor bias for decades, and the ethical codes of counseling associations (i.e., ACA, 2014; AMHCA, 2015) compel CMHCs to be aware of how their values, beliefs (including political beliefs), and biases inpact their work and to avoid imposing those beliefs on their clients. Accordingly, the relationship between the political beliefs and values of CMHCs and their clinical work is a salient issue in the field.

Perceived Level of Seriousness of Clinical Problems, Political Ideology, and Political Party Affiliation

On average, conservative and Republican CMHCs rated most clinical problems described in vignettes as being more serious than other CMHCs with the exception of gun storage (for both conservative and Republican CMHCs) and gender dysphoria (for conservative CMHCs), much like PCPs who participated in Hersh and Goldenberg's (2016) study inspired the current study. However, these differences were small, and when demographic variables of age, gender, race, ethnicity, and religious affiliation were controlled for, only two vignettes involving politicized issues (i.e., gun storage and abortion) yielded statistically significant differences. These differences were noted among CMHCs who described their political ideology as conservative, but they did not apply to CMHCs who identified as Republican. This finding contradicts results

obtained by Hersh and Goldenberg (2016), whose data yielded a significant difference between Republican and Democratic PCPs and perceived level of seriousness for abortion, gun storage, and marijuana vignettes.

Several factors may explain this difference in finding. First, there were some differences in design between the two studies. For example, Hersh and Goldenberg (2016) obtained contact information for potential participants through the National Provider Identification (NPI) database, solicited their participants through mail, and verified political party registration through a software program called Catalist, whereas in the present study I solicited participants who were members of AMHCA, were accessing the AMHCA online community forum, and were willing to complete an electronic survey as opposed to a mail-in survey, raising the question of whether CMHCs who participated in my study might be different in some respects from the general population of CMHCs. It is also possible that some participants misreported their political party affiliations, which presumably could not have happened with Hersh and Goldenberg's (2016) sample. Additionally, I compared Republican CMHCs to all CMHCs of all other political parties, whereas Hersh and Goldenberg (2016) compared Republican PCPs to Democratic PCPs, thus excluding all PCPs who were registered with other political parties or who had no political party affiliation.

However, two arguments unrelated to study design may provide a more plausible explanation for the difference in findings. First, as a group, CMHCs are more politically homogenous as compared to PCPs. Hersh and Goldenberg (2016) noted that their participants were nearly evenly split between Republican and Democratic parties, whereas in the current study CMHCs were 2.7 times as likely to identify as Democrats than Republicans. Similarly, CMHCs were 2.6 times as likely to identify as conservative than as liberal. These numbers are

similar to a previous study of CMHCs conducted by Norton and Tan (2019). It is possible that in comparison to PCPs, even conservative and Republican CMHCs are less politically conservative or less politically polarized. This would be the case if, for example, individuals who are more moderate in their ideology are attracted to the clinical mental health counseling profession. Second, the counseling profession explicitly and specifically teaches CMHCs to be aware of their biases, including political beliefs, and to avoid imposing their beliefs on their clients. Whereas the ACA (2014) and AMHCA (2015) ethical codes include them, a cursory review of the American Medical Association's (AMA) *Code of Ethics* yields no such provisions. In fact, the messages contained in both codes as they relate to the beliefs and biases of the practitioner appear contradictory. For example, the ACA (2014) code reads:

> A.11.b. Values Within Termination and Referral
>
> Counselors refrain from referring prospective and current clients based solely on the counselor's personally held values, attitudes, beliefs, and behaviors. Counselors respect the diversity of clients and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature (p. 6).

In comparison, the AMA (n.d.) code reads:

> However, physicians are not ethically required to accept all prospective patients. Physicians should be thoughtful in exercising their right to choose whom to serve.
>
> A physician may decline to establish a patient-physician relationship with a prospective patient, or provide specific care to an existing patient, in certain limited circumstances:
>
> > (a) The patient requests care that is beyond the physician's competence or scope of practice; is known to be scientifically invalid, has no medical indication, or

> cannot reasonably be expected to achieve the intended clinical benefit; or is incompatible with the physician's deeply held personal, religious, or moral beliefs in keeping with ethics guidance on exercise of conscience (p. 2).

Whereas the ACA *Code of Ethics* explicitly prohibits counselors from terminating a client and referring that client to another provider based on the counselor's "personally held values, attitudes, beliefs, and behaviors" (ACA, 2014, p. 6), the AMA *Code of Ethics* contains a provision that allows and perhaps encourages physicians to discharge or refer to other providers those patients whose requests are "incompatible with the physician's deeply held personal, religious, or moral beliefs" (AMA, n.d., p. 2). The only exception noted in the AMA code is for "cases of medical emergencies" (AMA, n.d., p. 2).

Treatment Decisions, Political Ideology, and Political Party Affiliation

When demographic variables of age, gender, race, ethnicity, and religious affiliation were controlled for, regression analyses revealed that there was no statistically significant relationship between conservative political ideology and the scores on treatment decision scales for each clinical vignette. However, there was a statistically significant relationship between Republican Party registration and the scores on treatment decision scales for the tobacco and gun storage vignettes. This finding contradicts results obtained from Hersh and Goldenberg (2016), whose regression analyses revealed statistically significant differences between Republican and Democratic PCPs on several treatment decisions, especially those related to politicized issues (e.g., marijuana use, abortion, gun storage). In addition to study design differences and differences in the ethical training of CMHCs and PCPs noted in the previous section, it is possible that if additional regression analyses were conducted on individual items for each vignette rather than treating the items from each vignette as a scale (as was the case in Hersh and

Goldenberg's study), additional significant differences will be identified. The finding that Republican CMHCs scored lower on the treatment decision scale for the tobacco vignette is somewhat perplexing. In national polling data, Republicans are slightly less likely to report tobacco use as compared to Democrats (e.g., Carroll, 2004). Additional analyses that examine each individual item on the tobacco use vignette decision scale might be helpful.

Conclusions

Conservative and Republican CMHCs rated level of seriousness of clinical vignettes politicized differently than other CMHCs. Although most of these differences were too small to be statistically significant, two exceptions were supported by the data, including political ideology and gun storage ($F(10,119) = 2.66$, $p = .006$, $R^2 = .183$, $R^2_{\text{Adjusted}} = .114$) and political ideology and abortion ($F(10,116) = 2.01$, $p = .038$, $R^2 = .148$, $R^2_{\text{Adjusted}} = .074$). However, there were no statistically significant differences between political ideology and scores on treatment decision scales for either item. Conversely, no statistically significant differences were noted between the perceived level of seriousness of politicized issues and political party affiliation, nor were there significant differences between the treatment decisions of Republican CMHCs and their non-Republican colleagues on most politicized issues with one exception involving the gun storage vignette ($F(10,129) = 2.948$, $p = .002$, $R^2 = .199$, $R^2_{\text{Adjusted}} = .131$). To further complicate the issue, there was a significant difference between treatment interventions selected by Republican and non-Republican CMHCs for one non-politicized issue (i.e., tobacco use) but not between conservative and non-conservative CMHCs. In totality, these mixed results suggest that extent to which political party and political ideology influenced perceptions of seriousness and treatment decisions was limited. Given the differences between the current study's results involving CMHCs and Hersh and Goldenberg's (2016) results involving PCPs, coupled with

differences in ethical standards pertaining to values and clinical work between the two professions, one viable possibility is that CMHCs fare better at avoiding values imposition in their clinical work as compared to PCPs. Perhaps, as Haidt (2012) observed, the differences in reasoning and decision-making between conservatives and liberals are often overplayed, and perhaps this is all the truer for CMHCs. Additional research is warranted to further explore this possibility.

Limitations

Five limitations of the current study have been identified.

Volunteer and Selection Bias

All CMHCs who participated in the study were members of AMHCA at the time of survey completion. There are approximately 140,760 CMHCs in the United States (HRSA, 2020), and there are only approximately 5,600 are members of AMHCA. There could conceivably be differences between CMHCs who join or support associations in their profession and those who do not. Additionally, research invitations were posted in AMHCA's online community forum, and there is no way to determine whether members who use the forum and who viewed the research announcement differ from those who did not. Lastly, there could be differences in beliefs or values relevant to the study between those who volunteered to participate in the survey and those who didn't (Sheperis, Young, & Daniels, 2017), although the study announcement did not reveal the study's focus on political ideology and party affiliation.

Ecological Validity

In the current study, CMHCs were given fictitious clinical vignettes as well as a prepared listing of possible treatment interventions to choose from. CMHCs were aware, therefore, that they were not making decisions in an organic clinical environment, raising the question of

whether results from the current study generalize well to "real-world" clinical environments (Sheperis, Young, & Daniels, 2017).

Limitations of Correlational Research

Correlation is not equivalent to causation. Although regression analyses controlled for age, gender, race, ethnicity, and religious affiliation, many other potentially confounding or extraneous variables exist. Causal interpretations of the study's data are therefore tentative at best (Sheperis, Young, & Daniels, 2017).

Study Design Variations

As previously noted, there were differences in the design of the current study and the design of the Hersh and Goldenberg's (2016) study involving PCPs as a point of comparison, including the selection process, the operationalization of political party (i.e., reported political party vs. confirmed political party), and the decision to combine treatment decisions for each vignette into a treatment decision scale for simplified data analysis. It is possible that adjustments in these design aspects may have yielded different findings.

Small Group Sizes

Although it was helpful to determine the prevalence of various political ideologies and party affiliations among participants, some of the political ideology and political party groups (see Tables 3 and 4) were very small, posing the challenge of how to extract meaningful information from small group sizes. In the current study, conservative CMHCs were compared to CMHCs who did not identify as conservative, and Republican CMHCs were compared to CMHCs who did not identify as Republicans. This is one way to examine differences between CMHCs of various political ideologies and political parties, but there are other ways to do so.

Additional analyses using data from the current study might compare liberal and conservative CMHCs and/or Republican and Democratic CMHCs to determine whether between-group differences are more pronounced than in the current study, though such analyses might result in smaller effect sizes due to smaller sample size. Future studies with larger sample sizes would therefore be helpful.

Suggestions for Future Research

The data used for the present study might be used to explore additional research questions not addressed in the current study, including:

1. What is the relationship between CMHCs' political ideology and/or political party and the likelihood that CMHCs will document and/or address problems related to politicized issues?
2. What is the relationship between CMHCs' political ideology and/or political party and the likelihood of selecting specific treatment plan interventions on each scale?

Subsequent studies exploring similar research questions might involve direct replication of the current study's findings as well as adjustments in study design to determine if alternative study designs yield similar findings. Quantitative data garnered from the current study provides very little information about the reasoning process of CMHCs when choosing various treatment interventions. Qualitative research often explores the viewpoints of participants in greater depth (Sheperis, Young, & Daniels, 2017). Qualitative and/or mixed methods study designs may therefore provide a deeper understanding of how political beliefs and values impact clinical work in ways that quantitative research cannot by examining why CMHCs choose particular interventions. Such research may yield additional information about the impact of values, beliefs, and biases on clinical work.

Consider three examples of the limitations of quantitative analysis in this regard. One of the treatment decision scale items in the marijuana vignette of the survey used in the current study includes the item, "Ask about motivation to stop using." It is possible for two participants to rate the likelihood of selecting that intervention with an identical number (e.g., 8) for two very different reasons; one for the intention of boosting the client's motivation to stop using (i.e., a focus on helping the client to abstain) and the other to determine how to support the client in whatever the client's goal might be (i.e., honoring the client's autonomy). Similarly, two participants who rated the likelihood of "explain[ing] that you do not write letters attesting to the need for emotional support animals" as a 10 might do so for very different reasons; one because she has not had appropriate training and fears that her letter would be insufficient and therefore rejected by airline personnel, and the other because she is philosophically opposed to emotional support animal letters, viewing them as a form of "coddling" or of fostering codependency between a client and a pet. As a final example, consider the option "administer tests designed to detect malingering or feigning of symptoms" in the vignette in which a client with Gender Dysphoria seeks a surgical procedure for female-to-male transition. One CMHC may rate the probability of choosing this intervention as high because he is highly skeptical of the legitimacy of Gender Dysphoria as a mental disorder, viewing the phenomenon as a form of attention-seeking or identify confusion, whereas another CMHC might choose this intervention because she knows from experience that insurance companies are less likely to authorize the procedure, which she thinks is likely integral to the client's recovery, without sufficient testing to demonstrate the legitimacy of medical need.

A previous study conducted by Norton and Tan (2019) examined the relationship between political beliefs and ideologies and preferred counseling theories. The current study

raised the level of inquiry one level by examining relationships between political ideology, political party affiliation, and treatment decisions in clinical vignettes. A third level of research might involve study designs involving authentic counseling environments and clients rather than artificial scenarios in order to improve ecological validity and generalizability. An additional branch of research might examine the question of how the match between client and counselor political ideology might impact the therapy experience and outcome. For example, do clients report a stronger therapeutic alliance when they sense that their CMHC has similar political ideologies? Do they feel more comfortable with CMHCs who identify with the same political party as they do? Do they have better treatment outcomes? Additionally, research can be conducted on the impact of the political ideologies of (a) counselor educators and their instructional methods, (b) clinical supervisors and their supervision methods, (c) counseling researchers and their chosen areas of research (i.e., a shortage of conservative researchers in the research field could potentially mean that certain research questions are less likely to be explored and/or are explored pejoratively), and (d) counseling association leadership and association position statements, legislative actions, and other projects.

Implications for the Field

Clinical mental health counseling is defined by AMHCA as "the provision of professional counseling services involving the application of principles of psychotherapy, human development, learning theory, group dynamics, and the etiology of mental illness and dysfunctional behavior to individuals, couples, families and groups, for the purpose of promoting optimal mental health, dealing with normal problems of living and treating psychopathology" (AMHCA, 2017). Given the intimate nature of their work, CMHCs are entrusted by their clients with highly sensitive and personal information, and CMHCs are often

afforded a position of great influence in the lives of their clients. This responsibility is a grave one and is embodied in AMHCA's *The Clinical Mental Health Counselor Declaration: A Hippocratic Pledge*:

> …I will engage in my profession with integrity and in keeping with codes of ethics, laws, and the best practices of Clinical Mental Health Counseling;
>
> I will maintain the upmost respect for each individual and will honor their autonomy, dignity, and self-determination;
>
> I will respect the confidences that are disclosed to me, in accordance with relevant laws and codes of ethics;
>
> I will recognize and address presumptions related to gender, age, race, ethnic origin, sexual orientation, disease, ability level, creed, nationality, or any other factors so they will not interfere with my duties;
>
> I will honor my professional capabilities, so that even under threat, I will not violate human rights or civil liberties…(AMHCA, 2020, p. 1).

Because of the nature of their work, CMHCs are obligated by their ethical codes (e.g., ACA, 2014; AMHCA, 2015) to be aware of the impact of their beliefs and biases on their work and to avoid imposing their values on their clients. The political beliefs and ideologies of CMHCs are part of their worldview, and without intentional effort on the part of CMHCs, these beliefs may impact client care. In addition to examining how one's worldview impacts counseling theory, CMHCs should strive to identify how their worldview impacts their political beliefs and values and, in turn, how those beliefs and values might impact their work when clients present with problems and concerns that relate to politicized issues.

Additionally, as gatekeepers of the profession, counselor educators, clinical supervisors, and counseling researchers should examine how their political beliefs and values effect how they interact with their students and supervisees, as such interactions may play a role in how the clinical work their students and supervisees engage in. Stiksma (2021) recently provided data from The Heterodox Academy's Campus Expression Survey, concluding that Republican students are reluctant to speak in class. It would be helpful to determine whether this is true in counselor education programs, and how this reluctance effects professional development. Counselor educators may find it helpful to examine instructional methods that encourage open discussion and collaboration between counseling students. Counselor educators may also attempt to identify keep points on various sides of politicized issues to avoid being experienced by students as "one-sided,"

Duarte, Crawford, Stern, Haidt, Jussim, and Tetlock (2015) observed that social psychology had become less political diverse over time and opined that the field of social psychology would benefit from political diversity due to bias in the profession, arguing that researchers "may concentrate on topics that validate the liberal progress narrative and avoid topics that contest the narrative" (p. 5). The same may be true for research in counselor education. Evans (2013) analyzed articles published from 1981 through 2011 in two flagship journals in the counseling profession, including the *Journal of Counseling & Development* (the counseling profession's first journal) and *Counselor Education and Supervision*, finding that as males became less represented within the counseling profession, fewer articles were published on the treatment needs of men, despite that half of the population served by counselors are men and that men have poorer mental health and wellness outcomes as compared to women in many

respects. Evans (2013) described reaction to these findings from peers in counseling research thusly:

> In conducting this content analysis, I was surprised at the scarcity of counseling literature focused specifically on men in both journals, especially *CES.* When I asked colleagues about this lack of research, I was surprised at the responses. They included responses such as, "All counseling is diverse." "Why the emphasis just on men?" "We need to focus on women, too." "Men are included in gender identity development." (pp. 471-472).

If Evan's (2013) assertion that a scarcity of men in the counseling profession translates into a scarcity of research on men's issues was presumed valid, then perhaps it would also be valid to question whether the scarcity of conservative researchers and professors in counselor education correlates with a scarcity of research on conservative issues. Counseling researchers should examine how their political beliefs impact their research.

Lastly, counseling association leadership should examine how their political beliefs impact their work mediating between the profession and social institutions such as government, as is the case with professional advocacy and lobbying activities. For example, after the Affordable Care Act, legislation primarily supported by liberals and opposed by conservatives, was passed in 2010, the American Counseling Association published a document entitled *The Affordable Care Act: What Counselors Should Know* (ACA, 2012) that outlined a number of beneficial aspects of the legislation but did not include any of the potential drawbacks of the legislation, including those that directly impact both counselors and their clients (e.g., some clients would see increases in their insurance premiums and/or would lose their current plans, a reduction in private pay services to counselors coupled with an increase in reduced payment from insurers was projected), despite that the media and other authorities within the counseling

profession were identifying them (e.g., Holan, 2013; Nordal, 2012; Rodriguez, 2014). (It is perhaps ironic that the insurance plan I purchased through the American Counseling Association as a membership benefit for a discounted rate of $89 per month became illegal under the Affordable Care Act and was replaced with a four-fold increased premium that was compliant with the law.) Similarly, the Executive Director of the American Mental Health Counselors Association (AMHCA) published an article entitled *Independence, Thanks to Obamacare* (Miller, 2016), in which he supported the legislation and identified that "the provision of health insurance and health care through consistent coverage should be essential to an authentic realization of the American values of independence, fairness and opportunity" (p. 2). Again, no drawbacks of the legislation were noted in the article. While it is understandable that the leaders of counseling associations would have opinions on legislation impacting the counseling profession, would notify their members of the benefits of such legislation, and might even endorse legislation such as the Affordable Care Act, failure to inform their members of the drawbacks of legislation as they relate to their members' counseling practices and their clients' insurance policies and premiums might be related to political bias within association leadership, perhaps warranting an additional direction for future research on political bias within the counseling profession.

Some counseling associations are becoming aware of the importance of taking measures to account for political bias when considering political action on the part of CMHCs. For example, in response to feedback from its members on the perception that legislation was sometimes being supported without the active participation of its members, the Florida Mental Health Counselors Association (FMHCA), a state chapter of AMHCA, adopted a procedure for addressing requests to support legislation in December 2019. The procedure involves a

committee researching the potential benefits and drawbacks of legislative actions, determination of the connection between the legislation and the mission and purpose of FMHCA, identification of any connection between the political issue and the *AMHCA Code of Ethics*, consultation with FMHCA's lobbyist and Ethics Committee, formal solicitation of the opinions of FMHCA members, and a final vote from FMHCA's Board of Directors (see Appendix C). To date, the procedure has been used to guide decisions on legislation related to issues such as a proposed ban on reparative or conversion therapy for minors, a streamlined licensure endorsement process for CMHCs coming to Florida from other states, the performance of forensic evaluations by CMHCs, and adjustments in supervision requirements for registered mental health counselor interns working in private practice. The development of procedures such as those utilized by FMHCA might be helpful in compensating for political bias within counseling associations.

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Appendices

Appendix A: Study Survey

Please confirm that you are currently licensed as a counselor by one or more state(s) in the United States and that you are not taking the survey on behalf of someone else.

° I confirm that I am licensed as a counselor (e.g., LPC, LCPC, LPCC, LMHC, LCMHC, LMHP-CPC, LPC-MH), that my license is active, and that I am not taking the survey on the behalf of someone else.

Please answer the following demographic questions:

Age (in years): _____

Sex: ° Male ° Female

Gender: ° Male ° Female ° Other

Race: ° White ° Black or African American ° Asian
° American Indian or Alaska Native
° Native Hawaiian and Other Pacific Islander ° Other

Ethnicity: ° Hispanic or Latino ° Not Hispanic or Latino

How many years have you been in practice? _____

In what state(s) do you hold a counseling license? _____

What is your primary work setting?

° Business/Industry ° College or University
° Correctional Facility ° Counseling Agency-Private
° Government-Federal ° Government-State/County/City
° Hospital ° Insurance Company
° K-12 School ° Pastoral/Religious
° Self-Employed/Private Practice ° Other

Religious Affiliation:

° Protestant ° Christian (nonspecific) ° Catholic
° Jewish ° Mormon
° Muslim ° None ° Other

How important would you say religion is in your life—very important, fairly important, or not very important?

° Very Important ° Fairly Important
° Not Very Important ° No Opinion

Sexual Orientation:

° Heterosexual ° Homosexual ° Bisexual ° Other

Political Ideology:

° Conservative ° Liberal ° Libertarian
° Socialist ° Communist ° Other

Which political party are you registered with on your voter registration card?

° Constitution Party ° Democratic Party
° Democratic Socialists of America ° Green Party
° Independent Party ° Libertarian Party
° Reform Party ° Republican Party
° Tea Party ° No Party Affiliation (independent)
° Not Applicable/Not Registered to Vote ° Unknown

In general, upon interviewing a <u>new</u> client to your practice, how often do you inquire about the following attributes?

	Never	Rarely	Sometimes	Usually	Always
Employment history	°	°	°	°	°
Family history	°	°	°	°	°
Hobbies	°	°	°	°	°
Alcohol use	°	°	°	°	°
Marijuana use	°	°	°	°	°
Other recreational drug use	°	°	°	°	°
Tobacco use	°	°	°	°	°
Access to/use of firearms	°	°	°	°	°
Sexual behavior	°	°	°	°	°
Exercise	°	°	°	°	°

Regarding your initial interview with clients, does your practice offer guidelines or require you to cover a specific checklist or template of topics?

° My practice provides me with guidelines but no specific checklist or template
° My practice provides me with an assigned checklist or template of topics to cover
° My practice does not provide me with guidelines, a checklist, or a template/ I have sole discretion in this area.

Consider the following hypothetical situations.

Clinical Vignette #1 (Alcohol Use)
A healthy-appearing, 38-year-old male client presents for his initial interview. He does not have any known prior chronic medical issues. During the interview, the client acknowledges consuming about 20 alcoholic beverages in a typical week but denies any related physical concerns.

On a scale from 1 to 10, how serious of a problem would you consider this?

o o o o o o o o o o

1 2 3 4 5 6 7 8 9 10
Not at all serious Very serious

Would you typically document this behavior in the client record and/or discuss it further with the client? (check all that apply)

° I would document this behavior in the client record.
° I would discuss this behavior further with the client.
° I would neither document this behavior in the client record nor discuss this behavior further with the client unless I saw more reason to do so.

If you would discuss this behavior with the client during the initial interview or in subsequent appointments, would you:

	1 Definitely would not	2	3	4	5	6	7	8	9	10 Definitely would
Discuss health risks of drinking	°	°	°	°	°	°	°	°	°	°
Urge the client to cut down on drinking	°	°	°	°	°	°	°	°	°	°
Ask about readiness to cut down on drinking	°	°	°	°	°	°	°	°	°	°
Refer the client to a physician for a consultation to discuss	°	°	°	°	°	°	°	°	°	°

options for medications that target alcohol use	
Refer the client to Alcoholics Anonymous, Celebrate Recovery, SMART Recovery, LifeRing, or a similar peer support group	○ ○ ○ ○ ○ ○ ○ ○ ○ ○

Clinical Vignette #2 (Marijuana Use)
A healthy-appearing, 38-year old, male client presents for his initial appointment. He does not have any known prior chronic medical issues. During the interview, the client acknowledges using recreational marijuana approximately three times per week but denies any related physical concerns.

On a scale from 1 to 10, how serious of a problem would you consider this?

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

2 2 3 4 5 6 7 8 9 10

Not at all serious Very serious

Would you typically document this behavior in the client record and/or discuss it further with the client? (check all that apply)

° I would document this behavior in the client record.
° I would discuss this behavior further with the client.
° I would neither document this behavior in the client record nor discuss this behavior further with the client unless I saw more reason to do so.

If you would discuss this behavior with the client during the initial interview or in subsequent appointments, would you:

	1 Definitely would not	2	3	4	5	6	7	8	9	10 Definitely would
Discuss health risks of marijuana	○	○	○	○	○	○	○	○	○	○
Discuss legal risks of marijuana	○	○	○	○	○	○	○	○	○	○
Urge client to cut down on marijuana use	○	○	○	○	○	○	○	○	○	○

Ask about motivation to stop using	°	°	°	°	°	°	°	°	°	°
Refer the client to Narcotics Anonymous, Marijuana Anonymous, Celebrate Recovery, SMART Recovery, or a similar peer support group	°	°	°	°	°	°	°	°	°	°

Clinical Vignette #3 (Tobacco Use)
A healthy-appearing, 38-year old, male client presents for his initial appointment. He does not have any known prior chronic medical issues. During the patient interview, the patient acknowledges engaging in social smoking, consuming approximately 15-20 cigarettes per week (2-3 per day), a habit that began at age 18. The patient denies any related physical concerns.

On a scale from 1 to 10, how serious of a problem would you consider this?

○	○	○	○	○	○	○	○	○	○
1	2	3	4	5	6	7	8	9	10

Not at all serious Very serious

Would you typically document this behavior in the client record and/or discuss it further with the client? (check all that apply)

° I would document this behavior in the client record.
° I would discuss this behavior further with the client.
° I would neither document this behavior in the client record nor discuss this behavior further with the client unless I saw more reason to do so.

If you would discuss this behavior with the client during the initial interview or in subsequent appointments, would you:

	1 Definitely would not	2	3	4	5	6	7	8	9	10 Definitely would
Discuss health risks of his smoking	°	°	°	°	°	°	°	°	°	°
Urge client to quit/cut down on his smoking	°	°	°	°	°	°	°	°	°	°
Ask about the client's readiness to quit	°	°	°	°	°	°	°	°	°	°

Refer the client to a physician for a consultation to discuss options for smoking cessation medication	°	°	°	°	°	°	°	°	°	°
Refer the client to a smoking cessation support group	°	°	°	°	°	°	°	°	°	°

Clinical Vignette #4 (Intercourse with Sex Worker)
A healthy-appearing, 38-year old, male client presents for his initial appointment. He does not have any known prior chronic medical issues. During the interview, the client acknowledges having had sexual intercourse with sex workers several times in the last year. The client denies any physical symptoms related to sexual behavior.

On a scale from 1 to 10, how serious of a problem would you consider this?

○	○	○	○	○	○	○	○	○	○
1	2	3	4	5	6	7	8	9	10

Not at all serious Very serious

Would you typically document this behavior in the client record and/or discuss it further with the client? (check all that apply)

° I would document this behavior in the client record.
° I would discuss this behavior further with the client.
° I would neither document this behavior in the client record nor discuss this behavior further with the client unless I saw more reason to do so.

If you would discuss this behavior with the client during the initial interview or in subsequent appointments, would you:

	1 Definitely would not	2	3	4	5	6	7	8	9	10 Definitely would
Seek to learn why client seeks sex workers	°	°	°	°	°	°	°	°	°	°
Discuss health risks of soliciting sex workers	°	°	°	°	°	°	°	°	°	°
Discuss legal risks of soliciting sex workers	°	°	°	°	°	°	°	°	°	°
Urge client to stop soliciting sex workers	°	°	°	°	°	°	°	°	°	°

Refer client to Sex Addicts Anonymous, Sexaholics Anonymous, or a similar peer support/recovery group	○	○	○	○	○	○	○	○	○	○
Discuss impact on personal relationships	○	○	○	○	○	○	○	○	○	○
Screen for sexually transmitted infections and/or refer to a clinic for testing	○	○	○	○	○	○	○	○	○	○

Clinical Vignette #5 (Depression)
A healthy-appearing, 38-year old, male client presents for his initial appointment. He does not have any known prior chronic medical issues. During the patient interview, the patient acknowledges having intermittent bouts of depression. He completed a PHQ-9 screening tool in your office and scored a 10, suggestive of a moderate level of depressive symptoms. He denies suicidal thoughts.

On a scale from 1 to 10, how serious of a problem would you consider this?

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

1 2 3 4 5 6 7 8 9 10

Not at all serious Very serious

Would you typically document this behavior in the client record and/or discuss it further with the client? (check all that apply)

° I would document this behavior in the client record.

° I would discuss this behavior further with the client.

° I would neither document this behavior in the client record nor discuss this behavior further with the client unless I saw more reason to do so.

If you would discuss this behavior with the client during the initial interview or in subsequent appointments, would you:

	1 Definitely would not	2	3	4	5	6	7	8	9	10 Definitely would
Inquire about the context of the depression	○	○	○	○	○	○	○	○	○	○
Offer coping strategies and suggestions	○	○	○	○	○	○	○	○	○	○

Inquire about suicidal thoughts or behaviors	○	○	○	○	○	○	○	○	○	○
Refer the client to a physician for a consultation to discuss medication options for depression	○	○	○	○	○	○	○	○	○	○
Refer the client to a peer support group for individuals with depression	○	○	○	○	○	○	○	○	○	○

Clinical Vignette #6 (Firearms at Home)
A healthy-appearing, 38-year old, male client presents for his initial interview. He does not have any known prior chronic medical issues. During the patient interview, the client, who is a parent with two small children at home, acknowledges having several firearms at home.

On a scale from 1 to 10, how serious of a problem would you consider this?

○	○	○	○	○	○	○	○	○	○
1	2	3	4	5	6	7	8	9	10

Not at all serious Very serious

Would you typically document this behavior in the client record and/or discuss it further with the client? (check all that apply)
° I would document this behavior in the client record.
° I would discuss this behavior further with the client.
° I would neither document this behavior in the client record nor discuss this behavior further with the client unless I saw more reason to do so.

If you would discuss this behavior with the client during the initial interview or in subsequent appointments, would you:

	1 Definitely would not	2	3	4	5	6	7	8	9	10 Definitely would
Ask client about firearm storage practices	○	○	○	○	○	○	○	○	○	○
Discuss risks of firearms in the home	○	○	○	○	○	○	○	○	○	○
Urge client not to store firearms in the home	○	○	○	○	○	○	○	○	○	○

Clinical Vignette #7 (Obesity)
A 38-year old, male patient presents for his initial interview. He does not have any known prior chronic medical issues. During the patient interview, the client, who has a body mass index (BMI) of 31 indicative of obesity, acknowledges having no regular exercise. The patient denies any physical complaints related to his/her weight.

On a scale from 1 to 10, how serious of a problem would you consider this?

○	○	○	○	○	○	○	○	○	○
1	2	3	4	5	6	7	8	9	10

Not at all serious Very serious

Would you typically document this behavior in the client record and/or discuss it further with the client? (check all that apply)
° I would document this behavior in the client record.
° I would discuss this behavior further with the client.
° I would neither document this behavior in the client record nor discuss this behavior further with the client unless I saw more reason to do so.

If you would discuss this behavior with the client during the initial interview or in subsequent appointments, would you:

	1 Definitely would not	2	3	4	5	6	7	8	9	10 Definitely would
Inquire about time course of the obesity	○	○	○	○	○	○	○	○	○	○
Inquire about client's desire to lose weight	○	○	○	○	○	○	○	○	○	○
Discuss health risks of obesity	○	○	○	○	○	○	○	○	○	○
Discuss health advantages of exercise	○	○	○	○	○	○	○	○	○	○
Refer the client to a physician for a consultation to discuss medication options for obesity	○	○	○	○	○	○	○	○	○	○
Urge client to change dietary habits	○	○	○	○	○	○	○	○	○	○
Urge client to exercise	○	○	○	○	○	○	○	○	○	○

Refer the client to a peer support group such as Weight Watchers or Food Addicts Anonymous	°	°	°	°	°	°	°	°	°	°

Clinical Vignette #8 (Abortion)
A healthy-appearing 28-year old, female client presents for her initial interview. She does not have any known prior chronic medical issues. During the interview, the client acknowledges having had two elective abortions in the last five years. She denies any physical complaints or complications associated with these procedures. She is not currently pregnant.

On a scale from 1 to 10, how serious of a problem would you consider this?

○	○	○	○	○	○	○	○	○	○
1	2	3	4	5	6	7	8	9	10

Not at all serious Very serious

Would you typically document this behavior in the client record and/or discuss it further with the client? (check all that apply)
° I would document this behavior in the client record.
° I would discuss this behavior further with the client.
° I would neither document this behavior in the client record nor discuss this behavior further with the client unless I saw more reason to do so.

If you would discuss this behavior with the client during the initial interview or in subsequent appointments, would you:

	1 Definitely would not	2	3	4	5	6	7	8	9	10 Definitely would
Inquire about circumstances of these abortions	°	°	°	°	°	°	°	°	°	°
Discuss mental health aspects of abortion	°	°	°	°	°	°	°	°	°	°
Refer to a physician for discussion of contraception options	°	°	°	°	°	°	°	°	°	°
Encourage the client not to have future abortions	°	°	°	°	°	°	°	°	°	°

Refer the client to a peer support group for women who have had abortions	○	○	○	○	○	○	○	○	○	○

Clinical Vignette #9 (Couples Therapy with Lesbian Couple)
Two healthy-appearing women in their early 30s present for an initial interview. They reported that they are married and wish to adopt a child. However, they have been arguing a little more than usual lately, have a few areas of disagreement about childrearing practices, and would like to address these issues so that they can move forward with adoption. They deny any physical violence, substance abuse, nor infidelity in their relationship.

On a scale from 1 to 10, how serious of a problem would you consider this?

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

1 2 3 4 5 6 7 8 9 10

Not at all serious Very serious

Would you typically document this behavior in the client record and/or discuss it further with the client? (check all that apply)

° I would document this behavior in the client record.
° I would discuss this behavior further with the client.
° I would neither document this behavior in the client record nor discuss this behavior further with the client unless I saw more reason to do so.

If you would discuss this behavior with the client during the initial interview or in subsequent appointments, would you:

	1 Definitely would not	2	3	4	5	6	7	8	9	10 Definitely would
Inquire about the nature and context of their conflict	○	○	○	○	○	○	○	○	○	○
Inquire about levels of motivation to improve their relationship	○	○	○	○	○	○	○	○	○	○
Explain to them that you do not think you are the best therapist to help them and refer them to a colleague who you think is a better fit	○	○	○	○	○	○	○	○	○	○

Discourage adoption until they have resolved their presenting concerns	○	○	○	○	○	○	○	○	○	○
Provide them with psycho-education on parenting practices	○	○	○	○	○	○	○	○	○	○
Provide conflict resolution and conflict management skills training	○	○	○	○	○	○	○	○	○	○
Refer then to a parenting education/training class	○	○	○	○	○	○	○	○	○	○
Refer them to a relationship improvement support group	○	○	○	○	○	○	○	○	○	○

Clinical Vignette #11 (Emotional Support Animals)
A healthy-appearing 38-year old, male client presents for his initial interview. He does not have any known prior chronic medical issues. He reported that he struggles with depression and generalized anxiety. During the interview, he indicates that he is seeking a letter documenting that his dog is an emotional support animal and that he should be permitted to have his dog on planes with him.

On a scale from 1 to 10, how serious of a problem (i.e., the current lack of an emotional support animal letter) would you consider this?

○	○	○	○	○	○	○	○	○	○
1	2	3	4	5	6	7	8	9	10

Not at all serious Very serious

In response to the client's request, would you:

	1 Definitely would not	2	3	4	5	6	7	8	9	10 Definitely would
Explain that you do not write letters attesting to the need for emotional support animals.	○	○	○	○	○	○	○	○	○	○
Write a letter honoring the client's request, documenting	○	○	○	○	○	○	○	○	○	○

the need for an emotional support animal.	
Conduct a more thorough assessment to determine if the client meets diagnostic criteria for an anxiety or depressive disorder.	○ ○ ○ ○ ○ ○ ○ ○ ○ ○
Administer normed psychological tests designed to detect the presence of anxiety and depressive disorders.	
Administer tests designed to detect malingering or feigning of symptoms.	○ ○ ○ ○ ○ ○ ○ ○ ○ ○
Conduct a more thorough assessment to determine if the client's anxiety or depression constitute a disability.	○ ○ ○ ○ ○ ○ ○ ○ ○ ○
Inquire as to if and how the client's pet alleviates his or her symptoms when traveling.	○ ○ ○ ○ ○ ○ ○ ○ ○ ○
Discuss alternative options for addressing the client's depression and anxiety.	○ ○ ○ ○ ○ ○ ○ ○ ○ ○

Clinical Vignette #12 (Sex Reassignment)
A healthy-appearing, 25-year-old, male client presents for his initial interview. He does not have any known prior chronic medical issues. During the interview, the client discloses that he is transgender and is transitioning from female to male. He indicates that he would like to pursue sex reassignment surgery and is requesting a letter attesting to his Gender Dysphoria so that he can go forward with a mastectomy.

On a scale from 1 to 10, how serious of a problem (i.e., the request for a letter) would you consider this?

○ ○ ○ ○ ○ ○ ○ ○ ○ ○

1 2 3 4 5 6 7 8 9 10

Not at all serious Very serious

In response to the client's request, would you:

	1 Definitely would not	2	3	4	5	6	7	8	9	10 Definitely would
Explain that you do not write letters attesting to sex reassignment surgeries.	○	○	○	○	○	○	○	○	○	○
Write a letter honoring the client's request, documenting the need for a mastectomy.	○	○	○	○	○	○	○	○	○	○
Conduct a more thorough assessment to determine if the client meets diagnostic criteria for Gender Dysphoria.	○	○	○	○	○	○	○	○	○	○
Administer psychological tests or screening instruments designed to measure overall psychological wellness as well as the presence of pathology.	○	○	○	○	○	○	○	○	○	○
Administer tests designed to detect malingering or feigning of symptoms.	○	○	○	○	○	○	○	○	○	○
Discuss alternative options for addressing the client's gender dysphoria.	○	○	○	○	○	○	○	○	○	○

Appendix B: IRB Approval

RESEARCH INTEGRITY & COMPLIANCE
Institutional Review Boards, FWA No. 00001669
12901 Bruce B. Downs Blvd, MDC35, Tampa, FL 33612-4799
(813) 974-5638 FAX (813) 974-7091

November 18, 2019

Aaron Norton
L-CACHE - Leadership, Counseling, Adult, Career & Higher Education
4202 East Fowler Avenue, EDU105/Room 158C
Tampa, FL 33620

RE: **Exempt Certification**
IRB#: Pro00042191
Title: Political Ideologies, Political Party Affiliation, and Treatment Decisions of Clinical Mental Health Counselors

Dear Mr. Norton:

On 11/16/2019, the Institutional Review Board (IRB) determined that your research meets criteria for exemption from the federal regulations as outlined by 45 CFR 46.104(d):

(2) Research that only includes interactions involving educational tests(cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:(i) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects; (ii) Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or (iii) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by 45 CFR 46.111(a)(7).

As the principal investigator for this study, it is your responsibility to ensure that this research is conducted as outlined in your application and consistent with the ethical principles outlined in the Belmont Report and with USF HRPP policies and procedures.

Please note, as per USF HRPP Policy, once the exempt determination is made, the application is closed in ARC. This does not limit your ability to conduct the research. Any proposed or anticipated change to the study design that was previously declared exempt from IRB oversight must be submitted to the IRB as a new study prior to initiation of the change. However,

administrative changes, including changes in research personnel, do not warrant an Amendment or new application.

We appreciate your dedication to the ethical conduct of human subjects research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

Melissa Sloan, PhD, Vice Chairperson
USF Institutional Review Board

Appendix C: FMHCA Procedure for Addressing Requests to Support Legislation*

** Note to Reader: Procedure reprinted with the permission of Diana Huambachano, Executive Director of FMHCA, 3/21/21*

Florida Mental Health Counselors Association
2101 Vista Parkway
Ste. 250
West Palm Beach, FL 33411

Phone: 561-228-6129

www.FMHCA.org

FMHCA Government Relations Committee (GRC)
Procedure for Addressing Requests to Support Legislation
(Adopted 12/18/19)

1. If a FMHCA member, regional chapter leader, or external entity requests that FMHCA support a bill or other political action (B/PA), the request is forwarded to FMHCA's Government Relations Committee (GRC).
2. If the GRC elects to consider supporting the legislative action, the GRC analyzes the bill or other political action and generates a report including
    a. a summary of what the B/PA does,
    b. potential benefits of supporting the B/PA,
    c. potential drawbacks of supporting the B/PA,
    d. any concerns about the B/PA,
    e. any relationship of the B/PA with the *AMHCA Code of Ethics* (may need to consult with Ethics Committee as part of the process), and
    f. an opinion on how support of the B/PA fits FMHCA's purpose and mission.
3. The GRC is encouraged to consult with FMHCA's lobbyist for assistance with analyzing the B/PA.
4. The GRC coordinates with FMHCA administrative staff to launch a survey and send it out to FMHCA members on whether the membership would like FMHCA to support the B/PA. The survey should include information that members can use to help them understand the B/PA. The GRC takes membership responses into consideration when deciding whether to recommend that FMHCA support the B/PA.
5. The GRC forwards its report and recommendation on whether to support the B/PA or not to the FMHCA Board of Directors (BOD).
6. If the BOD determines that the legislative action should be supported, the BOD may decide to issue a press release, position statement, and/or a "call to action" for members providing them with instructions on how to advocate for the legislative action. The BOD is encouraged to consult with the FMHCA lobbyist prior to release of such documents.

About the Author

Aaron L. Norton earned his Bachelors of Arts in Psychology, his Master of Arts in Rehabilitation and Mental Health Counseling, and has completed doctoral coursework in Counselor Education and Supervision at the University of South Florida. He is a Licensed Mental Health Counselor and Licensed Marriage and Family Therapist with certifications in addictions, rehabilitation counseling, clinical mental health counseling, trauma treatment, forensic mental health evaluation, and forensic behavioral analysis. He has served in several leadership positions in the Florida Mental Health Counselors Association, American Mental Health Counselors Association (AMHCA), and the National Board of Forensic Evaluators and is a consulting editor for AMHCA's *The Advocate Magazine*. He works in a private practice providing individual, couples, and family psychotherapy; clinical and forensic evaluation; clinical supervision; and professional training and consultation. He has received several awards from associations in the counseling profession and has been published in several counseling magazines and academic journals in the counseling field. For more information about him, visit www.anorton.com.