“That’s My Sincerely Held Principle”: Tennessee Mental Health Providers’ Perceptions of Ability to Refuse Services

By

Sally Warren

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of Masters of Sociology

Middle Tennessee State University

November, 2021

Thesis Committee:

Dr. Adelle Monteblanco (chair)

Dr. Vicky MacLean

Dr. Meredith Dye

DEDICATION

To Mom, Dad, and Ashlyn. Though you might not always understand what I do, your continued belief in my potential is something I will always be grateful for.

ACKNOWLEDGMENTS

I would like to extend my sincerest thanks to my faculty advisor and thesis committee chair, Dr. Adelle Monteblanco. Your guidance, support, and compassion are invaluable and have made this thesis possible. I feel extremely lucky to have worked alongside you since I started this journey in 2019. No one can light a fire under my feet quite like you can! I would also like to thank my committee members, Dr. Vicky MacLean and Dr. Meredith Dye. Dr. MacLean, thank you so much for your mentorship. You have guided me through the important milestones throughout this process, and your continued support humbles me! Dr. Dye, I am continually in awe of your expansive knowledge. I do not think a problem exists that you cannot solve. I am forever thankful for your assistance all of these years! I would also like to thank Dr. Rebekka King, who has become an incredible friend and colleague. Thank you for your professional guidance and encouragement. I would also like to acknowledge a particular Marriage and Family therapist, who made this research possible. Thank you so much for believing in my project and helping me get this out there! And I would also like to acknowledge all my professors here at MTSU and those throughout my time as an undergrad. Jamie Fuston, I thank you from the bottom of my heart for introducing me to sociology and continuing to mentor me today. You have been there since day one when I was just a timid college freshman. I would not have made it this far without you.

ABSTRACT

In 2016, then state Governor Bill Haslam signed Tennessee House Bill 1840 into law, which granted mental health providers the ability to decline services based on the "goals, outcomes, or behaviors that conflict with the sincerely held principles of the counselor or therapist" (Tennessee General Assembly 2020). Many perceive the law as explicitly targeting the LGBTQ+ community. Previous research has examined LGBTQ+ community members' perceptions of this law, but none has focused on mental health care providers' perceptions. I distributed an online survey to mental health care providers practicing in Tennessee to gauge their perceptions of this law. A content analysis was conducted on data gathered from seventeen respondents. I identified three themes in the data: a dedication to the Code of Ethics, boundary making, and conflicting perspectives. I found that those in the sample disagree with the law, but also have diverse viewpoints on the efficacy of the law.

TABLE OF CONTENTS

LIST OF TABLES

Amid a global pandemic and a political turning point in the United States, many people are taking to the streets to protest racism, sexism, and a plethora of other social issues embedded within the fabric of our social institutions. Within this activism are people bringing more attention to the issues facing the trans community. Trans individuals are those who do not identify with their gender assigned at birth. Activists within the trans community—along with their allies—are seeking legal protections, hoping that their states will enact laws and policies to protect them from discrimination. Additionally, they seek to challenge current laws that permit gender identity discrimination. The concerns of trans individuals are central to the current political climate, and many are tuning in very closely to how their states and local politicians are handling and speaking about trans rights.

It is no secret that trans individuals face discrimination every day. They often face violent attacks, aggressive treatment, slurs, and being refused services. These experiences can make trans individuals feel outcasted and alone (Puckett et al. 2020). The attack on their right to access healthcare is one of the many forms of discrimination. Healthcare providers are some of the most trusted individuals in our lives (Brenan 2018). When trans individuals are denied care, the consequences on their physical and mental health are severe (Spade 2015). Tennessee's therapy law—which allows therapists to refuse services to clients based on their held values—gives permission to therapists to discriminate against clients based on political and religious beliefs. This legal protection allows mental health providers to deny trans individuals from seeking mental health care, which is detrimental to the trans community here in Tennessee.[1] While previous research analyzed the perceptions and responses to the law from the LGBTQ+ community

(Grzanka et al. 2020), no research focuses on the perceptions of this law from mental health care providers themselves.

It is imperative to ask what mental health care providers think about this law. This law aims to protect the rights of mental health providers across Tennessee to decline services. Uncovering what providers think about the law needs to be communicated to those seeking mental health care. As Grzanka et al. (2020) found, trans individuals in TN are aware of the law and are concerned with how this law might deter those within the LGBTQ+ community from accessing mental health care, thus increasing their risk of mental health issues. Trans individuals stand to benefit from knowing what perceptions mental health providers have regarding TN HB 1840, as their acceptance or denial of this bill can influence how comfortable trans individuals are in seeking mental health care.

LITERATURE REVIEW

Sociologists disagree on how to best define "transgender" (Shuster 2020). For this project, I draw from Schilt and Lagos' (2017:427) definition, which is as follows: "Transgender is an umbrella term that refers to people whose gender identity does not necessarily correspond to the sex category to which they were assigned at birth." Transgender is an umbrella term that encompasses many other forms of identity. Some identify as nonbinary but closely identify with the term "transgender." Some also identify with other identities, such as genderqueer or gender non-conforming. The variety of ways trans people identify themselves plays a role in why sociologists have difficulty agreeing on a universal definition. But another factor in this issue is the field's own rocky past with including trans people in the dominant discourses and research.

The History of Trans Identity in Sociological Research

Schilt and Lagos (2017) examined the past fifty years of trans studies within sociology in the United States. They identified two main paradigms: a focus on gender *deviance* from the 1960s until the 1990s and a focus on gender *difference* starting in the 1990s and continuing into the present day. These paradigms offer a framework to view how trans individuals were perceived and written about in the field of sociology. The two paradigms seem to mirror the feminist waves, as feminist studies and sociology draw on each other (Schilt and Lagos 2017).

Before the 1960s, most research about trans identity and people was found in medical and psychiatric journals, mainly focusing on what was previously referred to as "sex reassignment surgery" (Schilt and Lagos 2017). Trans bodies and identities were pathologized and objectified, and many trans individuals felt troubled by this and began taking action. An increase in activism and trans scholars writing about their own experiences with their transitions caught the attention of sociologists (Schilt and Lagos 2017). Sociologists were curious about "transsexualism" and wanted to explore the medical process of transitioning in their research (Schilt and Lagos 2017).

Sociologists consider Harold Garfinkel's (1967) case study on Agnes as the first sociological analysis of a transitioning person. Also, it marks the beginning of the paradigm focusing on gender deviance (Schilt and Lagos 2017). Along with Garfinkel's research, other research emerging from this first wave of trans sociological study included social constructionist critiques of medical knowledge, feminist theory, deviance studies, and ethnomethodological approaches to gender (Schilt and Lagos 2017). The main focus of this paradigm was figuring out how to reconcile the emergence of this

medical diagnosis and the development of group identity (Schilt and Lagos 2017). Much of the research focused on medical involvement, as sociologists heavily analyzed the cultural significance and implications of medical gender transitions (Schilt and Lagos 2017). "Transsexuality" is a term that is not acceptable in the field today, as it is a harmful term and does not accurately define the trans community. This term is still present in the literature—but "transgender" is the correct term.

Moving to the 1980s, feminist sociologist Margrit Eichler describes gender reassignment surgery as "bodily mutation," further adding to the idea held by many other sociologists of her time who viewed biology as essential and immutable (Schilt and Lagos 2017). Likewise, this was noted in Raymond's (1979) use of the terms "female-to-constructed-male" and "male-to-constructed-female" as the inclusion of the word "constructed" implies that their identities are false and artificial (Schilt and Lagos 2017). Raymond (1979) asserted that those who fell outside of the gender binary should "embrace androgyny" to disrupt the gender dichotomy, as she argued that wanting to transition was reproducing the very traditional gender notions established by the patriarchy (Schilt and Lagos 2017). In explicit trans-exclusionary radical feminist action, Raymond (1979) also felt threatened and stated that trans women were a danger to the sanctity of women-only spaces and that trans women "colonized the female body and appropriated a feminist soul" (Schilt and Lagos 2017:428-429).

Then, during the 1990s, a clear shift in the paradigm occurred. Moving away from the idea that trans identity represents gender deviance, sociologists embraced the idea that trans identity is representative of gender difference. Whereas trans people were the *objects* of study—now they were the *subjects* of study. The gender difference paradigm

centered trans experiences as most important and expressed that these experiences were sociologically significant (Schilt and Lagos 2017). Another spike in activism and trans scholars drafting works on trans identity emerged, in tandem with the rising third wave of feminism, which encouraged marginalized individuals to speak and define their own lives and experiences. Namaste (1996) and Rubin (1999) disagreed with sociologists from the first paradigm. They argued that trans individuals were deliberately left out of research to share their thoughts and experiences about being trans (Schilt and Lagos 2017). They claimed that prior research reinforced the binary oppositions of academics against the people they study (Schilt and Lagos 2017). Not including trans people's perspectives in their research upheld the researcher's power dynamics, holding more power than the research subject. This paradigm of gender difference still dominates today as researchers continue to prioritize trans people's experiences and voices in sociological research on trans identity (Shuster 2019).

Despite the shift in how trans people are studied in sociology, this does not mean that trans research is given equal treatment in the discipline. Scholars who do trans research in sociology have difficulty publishing their research in general sociology journals as those journals see the research to be too specific and not of concern to broad sociology (Schilt and Lagos 2017; Shuster 2019). This leaves a large portion of trans research in sociology unpublished and inaccessible (Schilt and Lagos 2017; Shuster 2019). The view that trans research does not apply to general sociology journals represents a disciplinary barrier in prioritizing trans scholarship (Schilt and Lagos 2017; Shuster 2019).

Discrimination as a Social Barrier

The 2015 U.S. Transgender Survey is the largest survey on trans identity and experience in the U.S., with 27,715 respondents aged 18 and older (James et al. 2016). The survey was distributed online in both English and Spanish and across all 50 states. James et al. (2016) recruited participants by contacting around 400 active transgender, LGBTQ+, and allied organizations which then shared the survey information with their members. Respondents reported high instances of violence, harassment, and mistreatment. This included experiences of verbal harassment, physical attacks, and sexual assault as minors (James et al. 2016). A similar pattern was noted in the workplace, where respondents reported being fired or denied a promotion within the year before data collection or faced other types of mistreatments such as harassment and sexual assault as a result of their gender identity or expression (James et al. 2016). Outside of school and the workplace, most respondents reported being verbally harassed or sexually assaulted at some time in their life because they are transgender (James et al. 2016). Lastly, most measures assessing resources (employment, housing, etc.) across the survey revealed worsening rates as they intersected marginalization with disability and/or immigration status (James et al. 2016).

Discrimination against trans people seeking healthcare. Discrimination in the health care system is perhaps the larger body of study within trans research, where much of trans sociological research has focused on since the 1960s. Health insurance is an area of concern to trans individuals, as many are denied coverage based on identifying as trans (James et al. 2016). Trans people are often denied coverage for treatments and procedures related to transitioning, such as being denied coverage for hormone replacement therapy

and gender reassignment surgeries (James et al. 2016). In their online survey on minority stress and health of transgender individuals 16 and older, Puckett et al. (2020) found that 24% of respondents reported experiencing discrimination while seeking medical care.

Similarly, Bradford et al. (2013) found in their study on trans people in Virginia that 27% experienced discrimination in healthcare. Much of the discrimination in healthcare is attributed to providers' lack of knowledge regarding trans health and trans identity. Trans people often have to educate their health care providers about their identities which is a taxing feat. Many trans individuals who disclose their identity to their provider receive mistreatment and lack of respect (Bradford et al. 2013; James et al. 2016; Kattari et al. 2020; Kcomt et al. 2020; Mccrone 2018; Romanelli and Lindsey 2020; Wagner et al. 2016). Wagner et al. (2016) found through qualitative interviews with 17 trans individuals that they perceived most of the discrimination as unintentional and not malevolent—just a result of inexperience with trans people. The respondents noted that some of this came in the form of excessive questioning and attempts to reason about their trans identity from their providers (Wagner et al. 2016).

The Effects of Discrimination

Acts of discrimination always have a profound impact on those who receive them. Discrimination in one area of life can have a domino effect on other areas. A trans individual facing employment discrimination may be fired and have difficulty securing a new job because of their trans identity. Lack of employment means they can quickly fall into financial despair, leaving them impoverished and potentially homeless. They may lose their health insurance because they cannot make payments, and all of these events can cause extreme stress and anxiety (Hughto, Reisner, and Pachankis 2015).

Mental health. The mental and emotional impact of discrimination can lead to depression and anxiety (American Psychiatric Association 2017; Halliwell 2019; Puckett et al. 2020). Trans individuals also report higher psychological distress. Experiencing psychological distress can lead to suicidal thoughts and behaviors, and trans individuals have some of the highest rates overall compared to their cisgender counterparts (Bradford et al. 2013; James et al. 2016; Kattari et al. 2020; Kcomt et al. 2020; Mccrone 2018; Romanelli and Lindsey 2020; Wagner et al. 2016). In the U.S. Transgender Survey, 40% of respondents had attempted suicide at some point in their life (James et al. 2016). Additionally, 71% of those who had made a previous suicide attempt made more than one attempt in their lifetime (James et al. 2016). And 82% of all respondents reported suicidal thoughts at some point in their lives (James et al. 2016).

Avoiding care. As a result of negative experiences within healthcare, many trans individuals delay seeking healthcare altogether (Grzanka et al. 2020; James et al. 2016; Mccrone 2018). Fear of mistreatment due to their identity can deter seeking medical care, and past negative experiences can also be a source of stress and can cause trans individuals to avoid their doctors (Grzanka et al. 2020; James et al. 2016; Mccrone 2018).

TN HB 1840

Tennessee is among the first to pass legislation to strip anti-discrimination protections in mental health care away from the LGBTQ+ community. On April 27th, 2016, then state Governor Bill Haslam (Republican) signed Tennessee House Bill 1840 into law. It is the law that granted mental health providers the ability to decline services to anyone based on the "goals, outcomes, or behaviors that conflict with the sincerely held principles of the counselor or therapist" (Tennessee General Assembly 2021). The

details regarding the origins of the law are few and suggest a small group of individuals pushed this bill into the state legislature. Republican Senator Jack Johnson, representing District 23, sponsored the law. He explained that he did not write the bill and that "professionals" in the community brought it to him (Walsh 2016). The bill was drafted in response to the ACA's revision of their Code of Ethics in 2014, in which the ACA expects counselors only to refer clients when they do not have the skills to treat the client and not based on their beliefs or values (Walsh 2016). Tennessee is among many states to use the American Counseling Association's (ACA) Code of Ethics to base licensure standards of practice (Meyers 2016). Senator Johnson and the counselors who sponsored the bill argued that the referral guidelines were entirely new and unfair. However, the ACA Senior Director of the Center of Counseling Practice Policy and Research, Lynn Linde, stated that this is false and that the language was always in the Code of Ethics (Walsh 2016).

Other supporters of the law, such as David Fowler, the President of the Family Action of Tennessee, —stated that the bill protects counselors' "religious freedom"[2] (Walsh 2016). And, the Director for the Center for Relational Healing, Ken Graham, a Franklin, TN-based Licensed Professional Counselor with a Mental Health Services Provider designation, stated that the ACA's Code of Ethics put him and "other counselors in a bind if there is a conflict of interest" (Walsh 2016).

Essentially, this law allows any mental health care provider the ability to refuse treatment to any patient for almost any reason. Providers can pick and choose their clientele as they see fit. In March of 2016, two exceptions were added to the law after backlash: the first being that providers are required to refer patients to another therapist or

counselor after refusing treatment, and the second that if the patient is in any danger to themselves or others, the provider must treat them (Tennessee General Assembly 2021). Providers will not receive any professional or legal punishment if they refuse treatment to patients who are not at risk of hurting themselves or others. Still, they are held liable when the patients are in danger of harming themselves or others (Tennessee General Assembly 2021).

In early drafts of the law, the language explicitly stated the counselor's "beliefs" as a reason for refusal of treatment (Meyer 2016). Although the terminology changed in the final version of the law, the word "beliefs" caused many to perceive the law to be specifically targeting the LGBT community. Although the primary concern of the law to activists is how it will affect the LGBT community, the general vagueness of the law also means that anyone can be refused treatment. A therapist who disagrees with abortion may refuse to see a patient who has had an abortion. Likewise, mental health providers could refuse treatment to those with different religious or political beliefs. While the scope of this research focuses on the trans community, it is essential to note that the impact of this law spreads much further.

The ACA Code of Ethics. The ACA's Code of Ethics was first established in 1961. Since then, the ACA occasionally reviews and revises the Code of Ethics approximately every ten years. Revisions were made in 1974, 1981, 1988, 1995, 2005, and most recently, 2014 (Francis 2013). The revisions are made by the ACA's Ethics Revision Task Force. Counselors apply to be selected for the Task Force, and the ACA President reviews applicants and appoints members (Kaplan et al. 2015). Then, the Task Force spends time reviewing ACA member and counseling organizations' proposed changes,

reviewing global codes of ethics, reviewing relevant literature, and creating and revising drafts. Then, the final draft is sent to the ACA Governing Council for final approval (Kaplan et al. 2015).

Professional values are seen as a way to understand the relationship between society and the profession (Ponton and Duba 2009). Likewise, the ACA (2014:3) writes that "Professional values are an important way of living out an ethical commitment." The ACA's Code of Ethics applies explicitly to ACA members and is not a universally accepted code of ethics within the counseling profession (Dorn-Medeiros and Christensen 2019). However, twenty states adopt the ACA Code of Ethics as their official code of ethics (Francis 2013). Within the ACA's Code of Ethics, it specifies six areas of ethical principles as a foundation for ethical behavior and decision making: autonomy, nonmaleficence, beneficence, justice, fidelity, and veracity (ACA 2014). The Code of Ethics serves to define the ethical obligations of ACA members, act as a guide to navigating ethical concerns, uphold the ACA's principles, and serve as a basis for processing inquiries and ethics complaints regarding ACA members (ACA 2014). Scholars note that the ACA's Code of Ethics is simply a framework for ethical thinking and does not provide the answers to all ethical dilemmas (Ponton and Duba 2009).

What We Need to Know

There is widespread knowledge of the Tennessee Counseling Law in the LGBTQ+ community (Grzanka et al. 2020). Many aware of the law feel apprehensive about seeking mental health care in Tennessee (Grzanka et al. 2020). They are reluctant to trust mental health care providers because they fear potential discrimination (Grzanka et al. 2020). The perceptions of the LGBTQ+ community in Tennessee regarding this law

have been explored in previous research. But this reveals a lack of research done on the perceptions of this law held by mental health providers in the state of Tennessee. Therefore, there is a need to focus on mental health providers to add to the literature.

The questions I aimed to answer in my research were: Are mental health providers aware of TN HB 1840? What perceptions do mental health care providers have regarding the law? And, lastly, do mental health care providers report refusing services to clients because they are transgender?

METHODS

This study received Institutional Review Board approval from Middle Tennessee State University (Appendix B). The anonymous survey contained open and closed-ended questions asking counselors about their awareness, perception, and thoughts regarding the law. Consent was obtained at the start of the survey, and participants were asked to answer that they read the consent form and if they consented to participate. Data were collected and stored in Qualtrics, which was the software used to create and distribute the survey. Data was exported into an Excel document for analysis. Participants were unable to continue in the survey if they did not meet any of the following conditions: the participants must be 18 or older, a currently practicing mental health care provider, and practicing in Tennessee.

Survey Questions

After obtaining consent, participants were asked to report their licenses, if they had any. They were then asked how long they had been working in the field, what clients they primarily served, and if they had any specialty areas within counseling. They were also asked how often they had served trans clients in their practice. Then, participants

were asked, “Are you familiar with Tennessee House Bill 1840—the law that allows mental health providers the ability to refuse treatment to patients on the basis of sincerely held beliefs and values?” Regardless of whether they indicated “yes,” “no,” or “not sure,” a brief section detailing the law followed, including the law’s definition, when it was passed, and the later amendments added to the law. Participants were then asked an open-ended question: “What do you think about this law?” Participants were also asked closed-ended questions such as, “Do you agree with this law?” and “Do you think this law provides you with legal protections that you desire?” and lastly, “Have you ever refused treatment to a transgender patient treatment based on this law?” All closed-ended questions included a “don’t know” or “prefer not to answer” option and an “other” option when necessary.

Survey questions were informed by the literature review, so some terminology and questions were drawn from previous studies on the subject. For example, one open-ended question on the survey, “How would you define “sincerely held principles” in your practice as a mental health provider?” was pulled directly from Grzanka et al. (2020). I changed some parts of the question to be more specific to mental health care providers to fit my project better.

Demographics

Demographic information was collected on participants at the end of the survey. Participants were asked to report their race, ethnicity, age, sexual orientation, gender identity, religious affiliation, income, the highest level of education, political affiliation, what field their degree(s) was in, and their marital or relationship status. Participants

were given the option to skip demographic questions or select a "prefer not to answer" choice for all demographic questions.

Recruitment

Participants were recruited online by email and social media. The Tennessee Association of Mental Health Organizations (TAMHO) assisted in the participant recruitment process by sending the survey link via email to its members. Additional recruitment was achieved by a helpful gatekeeper—a Middle Tennessee-based Marriage and Family Therapist—who posted a digital flyer with the survey link and information directly in private Tennessee counselor groups on Facebook. No identifiable information was collected, nor did I have access to an email list of participants or names of group members on Facebook.

Participants

Seventeen individuals completed the survey and were included in the analysis. Due to the low number of responses, the initial proposal for quantitative analysis was changed, and a content analysis of the open-ended responses was completed instead. All 17 participants met recruitment criteria, and each held some form of licensure in the state. All participants had at least one year of experience working as a mental health provider, with the longest practicing participant having worked in the field for 17 years. Nine out of the seventeen respondents stated that they primarily served LGBTQ+ individuals, and three participants indicated that they specialized in LGBTQ+ issues. Their ages ranged from 25 to 47.

Additionally, 15 of the 17 held Master's degrees, and the remaining two had Doctoral or Professional degrees. The sample was diverse in sexual orientation. Six

participants identified as heterosexual, and three identified as queer. Four other respondents marked multiple sexual orientations; for example, two participants identified as both bisexual and pansexual, one participant identified as bisexual and demisexual, and one participant identified as homosexual, bisexual, and polysexual. In terms of gender identity, the majority of respondents identified as cisgender women. Only two out of the seventeen respondents identified as transgender and nonbinary. Additionally, the sample was overwhelmingly white, as 16 out of the 17 identified as white, and the remaining participant identified as Black or African American. See Table 1 in Appendix A for other demographics of the sample.

Analysis

Once the data collection period closed, the data was reviewed and cleaned to discard duplicate or incomplete responses. Next, the survey responses were exported into an Excel document to begin analysis. Analyses were conducted through the lens of qualitative content analysis, particularly utilizing an inductive approach. An inductive approach was chosen to construct common themes from detailed readings of the raw data without the constraints inflicted by structural methodologies (Thomas 2006). Through multiple readings of the data, categories were constructed from the frequent and dominant themes and concepts noted within the responses to the open-ended questions on the survey. These multiple readings resulted in specific categories; a process known as in vivo coding (Thomas 2006). Responses to the closed-ended questions were examined in conjunction with the open-ended questions. For example, I examined whether participants agreed with the law or not and then compared their answers to what they wrote regarding their thoughts about the law.

RESULTS

Upon analysis of the data, three major categories/themes emerged: dedication to the Code of Ethics, boundary making, and conflicting perspectives. Despite an overwhelming majority of respondents indicating disagreement with the law (14 out of 17 participants marked that they disagreed with the law), participants still expressed conflicting thoughts and feelings about the law. Additionally, there were numerous interpretations of the law, and participants discussed both the benefits and disadvantages of the law. To explore these themes, I include many quotes below, with minor grammatical and spelling corrections made.

Dedication to Code of Ethics

One of the most prominent themes within the data was the providers' perceptions of this law constructed through their understanding of the American Counseling Association's (ACA) Code of Ethics for their professional members. Participants centered the ACA Code of Ethics as a guiding principle for how they structured their practice. Participants who utilized the Code of Ethics in their responses communicated that the HB 1840 law was in direct conflict with their Code of Ethics, which has explicit guidelines for referring clients out of their practice. Many respondents communicated that they are only to refer out when they cannot adequately counsel a client, not based on the clients' gender, sexuality, or other identities. Two participants referenced ethics more broadly, referring to the law as "unethical."

Perceptions of the ACA Code of Ethics seemed to negate or outclass the law in the eyes of many of the respondents. Those who felt the law violated the Code of Ethics perceived it as transgressing ethics instead of establishing a new set of rights and rules.

Participants who did not explicitly mention ethics still framed many of their responses due to those ethics. For example, Participant P, a 43-year-old Licensed Professional Counselor (LPC) with 12 years of experience in the field, stated, “I think it is wrong morally to refer someone because of their race, gender, or sexual orientation, but I think that some clients need to be referred if they are not a good fit or the therapist is triggered by the client.” Notions of when it is okay to refuse services greatly depend on the context of the relationship between the therapist and client, as observed in their responses.

When asked to define “sincerely held principles” in their practice, participants also framed their answers in such a way dependent on ethics. Participant G, a 34-year-old Licensed Clinical Social Worker (LCSW) with ten years of experience, defined it as “My duty to my client, ethical standards, and best practices of care.” While Participant M, a 33-year-old LPC with Mental Health Service Provider designation (LPC-MHSP) with 13 years of experience, refused to define them: “I don’t even have a definition because following this law would mean shirking my professional ethical code—that’s my sincerely held principle.” It is clear that many respondents see the Code of Ethics as the primary source of how to practice counseling, and state laws come second.

Boundary Making

Another theme made evident through the data was boundary making. Participants established boundaries between themselves and their clients, emphasizing the need to remove the therapists’ personal values from their treatment of their clients. Also, participants frequently compared their thoughts regarding HB 1840 against hypothetical therapists, constructing a notion of the existence of “good” and “bad” therapists.

Who makes a "good" or "bad" therapist? Participants framed their explanations around the notion of who adheres to counseling values versus who does not. Participant B—a 25-year-old LPC-MHSP with one year of experience—questions, "If the counselor's beliefs were so rigid, why would they go into counseling?" Participant B expresses that providers going into the field must adopt a framework of leaving their beliefs at the wayside, and if they cannot do that, then counseling is not the best fit for that provider. Participant L, a 38-year-old LCSW with over 14 years of experience, stated similarly, "Clinicians need to be held to the standard of recognizing and managing their countertransference. If a clinician is unable to do so, the clinician is not fit to practice therapy. This is why clinicians also need to recuse themselves from practice if/when their countertransference is unmanageable." Participants argue that there is a rigid set of rules for who should and should not practice in the field of counseling. As Participant P states, "If bigotry stops a therapist from helping someone then, maybe they should find a different profession." These responses reflect the construction of who makes a good therapist versus who does not.

Rejecting or Redefining "Sincerely Held Principles." Many participants outright dismissed the language of the law entirely, creating a boundary between the law and how they implemented it into their practice. Participant J, a 42-year-old LPC-MHSP with over eight years of experience, states, "I don't define them in my practice because it's not about me." This statement again demonstrates the clear boundary many participants establish regarding their role within their practices. Others expressed difficulty in defining "sincerely held principles" within their practice, as Participant O, a 31-year-old Temporary LMFT (meaning they are working towards their license) with three years of

experience, describes, “I don’t know. I personally have some distinction between my PERSONAL sincerely held principles vs. my professional/general principles, for better or worse.” Interestingly, Participant O establishes a boundary between the personal and clinical, again harking back to the values put forth in the ACA Code of Ethics.

Many participants sought to redefine “sincerely held principles” that challenged the law’s intended notions. For example, Participant C, a 33-year-old LPC with seven years of experience, remarks, “My sincerely held principles include that everyone is deserving of compassionate care.” Likewise, Participant I, a 41-year-old LMFT with 17 years of experience, says, “My sincerely held principles are to serve all clients, regardless of my personal views and values.” These redefinitions seek to challenge the law and demonstrate the bill's vagueness, as it can be interpreted in different ways.

Conflicting Perspectives

Although most participants marked that they disagreed with the law, those who agreed, disagreed, or were unsure still predominantly expressed conflicting views of the efficacy and necessity of the law. Their answers, which varied amongst the questions I asked them, indicated that they had mixed perceptions of this law, and thus I named the theme accordingly. As Participant D—a 33-year-old LPC with five years of experience—explains:

> I don’t want to be forced to treat the guy who came in my office using the N-word over and over. I don’t want to be forced to treat transphobic people who think they’ll convince me of their viewpoint. Due to my trauma, I don’t think I should be forced to work with pedophiles who have acted on their drives. Due to my lack of training, I shouldn’t be forced to treat eating disorder clients. I know I can’t give good therapy to those people.

Participant D's reflection posits a unique consideration unlike many other respondents—the need for the therapist's wellbeing. Additionally, Participant D mentions a lack of training on eating disorders, thus making a case for incompetency as a legitimate reason to refer clients. Likewise, Participant J shares, "No, we should not refuse to treat a client because our beliefs don't match; it's not about us. AND, if we're not competent or have no experience, we shouldn't be forced to try. That's irresponsible as well." Although Participant J expresses those clients deserve treatment regardless of the therapist's beliefs, they are conflicted and still find an exception based on competency. The nature of the workplace also caused conflict for Participant K—a 40-year-old LCSW with six years of experience—who explains, "It greatly depends on the context. Private practice therapists have greater autonomy, but agency and hospital-based providers have different obligations to the general public. Overall, this is not something the state legislature should be getting involved in." These participants see the state law as something that looks different based on many factors, such as therapist competency and the setting in which the therapist practices.

Others were conflicted because they did not want clients to be treated by therapists who would not provide adequate therapy due to discriminatory beliefs. Participant P states:

> I think it's morally wrong to refer someone because of their race, gender, or sexual orientation, but I think that some clients need to be referred if they are not a good fit or if the therapist is triggered by the client. I think it can cause harm if the client is with someone who does not really want to treat them.

The notion that the therapist should "do no harm" resurfaces in this context—born directly out of the ACA's Code of Ethics. As stated in Section A.4.a: "Counselors act to

avoid harming their clients, trainees, and research participants and to minimize or to remedy unavoidable or unanticipated harm" (ACA 2014:4). Participant O demonstrates this in their statement:

> As someone who works with LGBTQ folx and folx who've had religious trauma, I mourn that my clients have been told things like "you should just pray more about that" by therapists, and it's probably for the best that they're not with those therapists anymore. However, there are a lot of issues, like anxiety, where therapists really should be able to help a given client even if the therapist doesn't *love* that the client is gay.

According to ACA's Code of Ethics and many of the respondents, such as Participant O, there are instances where therapists cause harm to their patients, even if they are expected to provide adequate therapy regardless of the client's identity. This can be a source of conflict when interpreting this law, as many respondents have expressed that this law allows therapists to remove themselves entirely from situations that would ultimately harm the client.

DISCUSSION

As shown from the results, my research questions were answered in numerous ways. My first question, "Are mental health providers aware of TN HB 1840?" was answered directly from my question if participants were aware of the law. Only one participant out of the 17 was not aware of the law before completing the survey. While my results are not generalizable, my sample expressed widespread knowledge of this law. My second question, "What perceptions do mental health care providers have regarding the law?" was answered through participants sharing their thoughts on the law and how they defined "sincerely held principles" in their practice, as demonstrated in the analysis section. My third question, "Do mental health care providers report refusing services to

clients because they are transgender?" was answered through my closed-ended question asking if they have ever denied services to trans clients based on this law. Moreover, I also asked participants how often they have served trans clients. The majority of the sample had experience with serving trans clients in some capacity. Five respondents reported serving trans clients very often, six reported somewhat often, four reported sometimes, one reported hardly ever, and one reported never serving a trans client. But, all 17 participants reported that they have never refused a client based on this law. However, it is essential to note the language included in my research question and my survey question. By asking if they have ever "refused" care, this leaves out the possibility that providers might have "referred" clients instead, which is not included in my questions. The practice and process of referral is important to explore in future research.

Scholarship on group dynamics seems to reflect the explanations provided by participants on what kind of therapists "should" practice. This sort of "litmus test" for counselors indicates an in-group and an out-group. The in-group is the preferred group, and the out-group is seen negatively (Scott 2014). The need to categorize individuals stems from self-categorization, which is seen as a basic human need (Aviram 2007). Participants who expressed views on who should and shouldn't be counselors see themselves as part of the in-group: those who adhere to the Code of Ethics and understand that their personal views should not interfere with their clients, effectively creating a "collective identity" (Aviram 2007). The providers who do not meet those standards are the out-group and are not worthy of being in the same profession as those within the in-group. This rejection of those who do not adhere to the Code of Ethics may stem from the perception that the Code of Ethics is how the profession of counseling was

legitimized. Professions aim to be legitimized in society, secure autonomy, guard their turf, and expand their jurisdiction (Mizrachi et al. 2005; Norris 2001). One way of doing this is to create ethics and a foundation that sets the organization apart, thus creating boundaries (Norris 2001). Professionals within the organization then seek to maintain these boundaries to uphold the profession (Norris 2001). As such, the Code of Ethics serves as a professional ideology for counseling, and counselors adopt this framework as a way of distinguishing themselves from others (Norris 2001). Participants often discussed "other" counselors—instead of framing their responses solely on their own beliefs, they often included other counselors (who may or may not be real) and explained why those counselors are wrong and unfit for the profession. Therefore, counselors understand their profession by constructing "us" vs. "them"—and they want to communicate that "they" are not "them" (Norris 2001).

Additionally, participants' responses can be viewed through the lens of symbolic interactionism. It is interesting to note that for a law so heavily based on religion, that participants did not discuss it often. What they did not say is important to examine. How the participants framed their responses matters, and many make sense of the law through their Code of Ethics. Less important are the therapists' values, and instead, their interpretations of the law solely rested on the tangible set of rules set forth by their profession. This dedication to the Code of Ethics might indicate a sense of using the Code of Ethics as a legitimate source to oppose the law instead of making their case based on their own opinions. The Code of Ethics can provide more "weight" to their responses as it is an official source for counselors. Participants referred to their Code of Ethics, concerns about clients being treated by prejudiced therapists, and considering their rights within

their practice. But virtually none of the participants wrote about the law's impact on trans individuals or anyone for that matter. I anticipated participants discussing how this law might drive trans clients away from seeking mental health care, but they did not include this in their thoughts about the law. It does not suggest that they are not concerned about it. Still, it does reveal that providers framed their ideas about this law on how counseling as a profession is affected and not necessarily how clients are affected.

Although participants talked about hypothetical therapists who used this law and agreed with it, there was not much representation amongst the sample of therapists who favor this law. Two participants in the sample agreed with the law. Still, their responses do not provide much insight into those who support this law. Through informal conversation with the gatekeeper referenced prior, I finally uncovered the specific individuals who were behind this law's origins, such as the Brentwood therapist, Senator Johnson, and David Fowler. Yet, this still begs the question, just how many therapists support this law? It is possible that this law is not necessarily representative of a majority of therapists' desire to have control over their clientele, but it instead may be symbolic in purpose. HB 1840's existence likely serves as an ideological statement—one that signifies that therapists should have the ability to incorporate their values and principles in their practice. Still, the previous language in the drafts of the bill reveals that this law had religious origins. This law is but one that reflects the political values of the state—that religious freedom remains essential, regardless of professional guidelines such as those in the ACA Code of Ethics.

Another interesting finding is that participants did not differ in their perspectives based on their religious and political affiliations. Five respondents identified as either

Protestant, Christian, or Catholic in the sample, and the remaining 12 identified as spiritual, agnostic, atheist, or unaffiliated. Although those who identified as religious were not more likely to have conflicting perspectives on the law or agree with the law, it is interesting to note their political affiliation. Four out of the five religious respondents marked that they were Democrat and Somewhat Liberal, and the other respondent, Participant J, identified as Republican and Somewhat Conservative. Upon comparing their responses, Participant J was conflicted on the law but still disagreed with the law. But the other religious participants who were Democrat and Somewhat Liberal were just as likely to have conflicting perspectives, so it does not appear that there was much difference based on religious and political affiliation. This could indicate that their perceptions were not affected by these affiliations but rather by their perceptions of ethical practice, likely influenced by the ACA Code of Ethics.

Moreover, the subtheme of professional competency repeated throughout many of the participants' responses indicates how some can find “loopholes” to avoid certain expectations within their work. Here, competency acts as a “scapegoat” of sorts that suggests that therapists, while being held to a certain standard by their Code of Ethics, can still opt out of treating specific clients based on their level of competency. While some participants regarded the ability to opt-out as a positive, where incompetent therapists could refer out to another provider who would provide adequate therapy, it does speak to the quality of training that therapists receive. If many therapists are incompetent in terms of trans or LGB issues in general, this reflects a lack of adequate training in the base curriculum for counseling, which is an issue also shared by the healthcare field in general, as doctors tend to lack training regarding trans individuals as

discussed earlier in the literature. Furthermore, the ACA's Code of Ethics (2014:5) even encourages counselors to "seek training in areas 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." Thus, holding therapists to a standard of incompetency is not an acceptable reason for referring clients according to the Code of Ethics, where it also states, "If counselors lack the competence to be of professional assistance to clients, they avoid entering or continuing counseling relationships" (ACA 2014:6).

LIMITATIONS

This research was designed to build upon Grzanka et al.'s (2020) research on perceptions of this law within the LGBTQ+ community by providing insight into how mental health providers in Tennessee perceived the law. While this study cannot be generalized due to a low number of respondents, this content analysis revealed some common and important themes. Future research should gather a larger sample to provide a quantitative analysis of providers' perceptions of the law. Additionally, I had a fourth research question asking how providers implement the law into their practice, but the data gathered did not easily answer this question and was thus discarded. Further research should also examine this question and seek to answer it through vignettes.

Another limitation of this research is the sample's lack of diversity in terms of race and ethnicity. Sixteen out of the seventeen respondents were white, one identifying as "Caucasian Jew," and only one identified as Black or African American (See Table 1). Further research on the topic should diversify the sample, perhaps by recruiting from groups and spaces dedicated to people of color within counseling.

The sample is also limited result of a potential selection bias. A high number of the sample disagreed with the law, indicating that it is possible that only those who had negative perceptions of the law were inclined to respond to the survey. It is possible that the gatekeeper who shared the link was against this law, and thus only members in the group who felt the same way decided to complete the survey. Only two respondents agreed with the law. Participant Q—a 38-year-old LCSW with 15 years of experience—was one of the respondents who agreed, and was also the only participant who was not aware of the law. The fact that only one respondent was not aware of the law also indicates that perhaps those who were not aware of the law did not feel inclined to respond to the survey, so this sample does not provide much insight into the perceptions of those who were not aware of the law.

CONCLUSION

In this time of heightened political awareness and activism, research must also follow suit and aim to reveal and address inequalities. The existence of TN HB 1840 sets a dangerous precedent that dehumanizes trans individuals and reduces their identities as nothing more than something for others to "disagree" with. Additionally, this law allows for the occurrence of countertransference—where therapists' feelings regarding their client are imposed on that client—which violates the ethical guidelines outlined in the ACA Code of Ethics. Since Tennessee adopts the ACA Code of Ethics for licensure standards, this law is contradictory.

This research was designed to seek knowledge for the benefit of the trans community in Tennessee. Mental health care must be accessible and affirming to those who need it, and those seeking mental health care should not have to wonder whether a

therapist or counselor will accept them or not. One way of ensuring trans individuals can find accepting therapists could be through online directories dedicated to listing trans-friendly providers in the state. Trans individuals may not have access to personal referrals from fellow trans community members, especially if they reside in rural areas where there are not as many proximate providers. These lists can provide a resource for those who do not have others to guide them to trans-friendly mental health providers. One limitation of this solution is that these online directories might place a target on the providers listed, opening them up to receiving hate and discrimination from anti-trans individuals in the state. Overall, this research provides an initial glimpse into what mental health providers think and how they interpret TN HB 1840.

ENDNOTES

[1]I use the terms “mental health provider,” “therapist,” and “counselor” interchangeably throughout the paper, as it reflects both the language used by my participants and the American Counseling Associations’ Code of Ethics.

[2]Middle Tennessee-based Marriage and Family therapist, personal interview with the author, October 7, 2021.

REFERENCES

American Counseling Association. 2014. “2014 ACA Code of Ethics.” Retrieved October 14, 2021, from (https://www.counseling.org/resources/aca-code-of-ethics.pdf).

American Psychiatric Association. 2017. “Mental Health Disparities: LGBTQ.” Retrieved December 9, 2019, from (https://www.psychiatry.org/psychiatrists/cultural-competency/education/mental-health-facts).

Aviram, Ron B. 2007. “Object Relations and Prejudice: From In-Group Favoritism to Out-Group Hatred.” *International Journal of Applied Psychoanalytic Studies* 4(1):4–14. doi: 10.1002/aps.121.

Bradford, Judith, Sari L. Reisner, Julie A. Honnold, and Jessica Xavier. 2013. "Experiences of Transgender-Related Discrimination and Implications for Health: Results from the Virginia Transgender Health Initiative Study." *American Journal of Public Health* 103(10):1820-1829. doi: 10.2105/AJPH.2012.300796.

Brenan, Megan. 2018. “Nurses Again Outpace Other Professions for Honesty, Ethics.” *Gallup*. Retrieved November 29, 2020, from (https://news.gallup.com/poll/245597/nurses-again-outpace-professions-honesty-ethics.aspx).

Dorn-Medeiros, Cort M., and Jeffrey K. Christensen. 2019. "Developing a Rubric for Supervision of Students Counseling LGBTQ Clients." *Journal of LGBT Issues in Counseling* 13(1):28-44. doi: 10.1080/15538605.2019.1565798.

Francis, Perry C. 2013. “Overview of Revisions to the American Counseling Association 2005 Code of Ethics.” *American Counseling Association*. Retrieved October 19, 2021 (https://www.counseling.org/docs/ethics/introduction_to_the_code_of_ethics).

Garfinkel, Harold. 1967. *Studies in Ethnomethodology*. Englewood Cliffs, NJ: Prentice-Hall.

Grzanka, Patrick R., Elliot S. Spengler, Joseph R. Miles, Keri A. Frantell, and Elliott N. DeVore. 2020. "“Sincerely Held Principles” Or Prejudice? The Tennessee Counseling Discrimination Law." *Counseling Psychologist* 48(2):223-248. doi: 10.1177/0011000019886972.

Halliwell, Pamuela. 2019. "The Psychological & Emotional Effects of Discrimination Within the LGBTQ, Transgender, & Non-Binary Communities." *Thomas Jefferson Law Review* 41(2):222-237. (https://ezproxy.mtsu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=lft&AN=137804082&site=eds-live&scope=site).

Hughto, Jaclyn M. White, Sari L. Reisner, and John E. Pachankis. 2015. "Transgender Stigma and Health: A Critical Review of Stigma Determinants, Mechanisms, and Interventions." *Social Science & Medicine* 147:222-231. doi: 10.1016/j.socscimed.2015.11.010.

James, Sandy E., Jody L. Herman, Susan Rankin, Mara Keisling, Lisa Mottet, and Ma’ayan Anafi. 2016. *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality. Retrieved October

19, 2021. (https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf).

Kaplan, David M., Perry C. Francis, Mary A. Hermann, Jeannette V. Baca, Gary E. Goodnough, Shannon Hodges, Shawn L. Spurgeon, and Michelle E. Wade. 2017. "New Concepts in the 2014 ACA Code of Ethics." *Journal of Counseling & Development* 95(1):110-120. doi: 10.1002/jcad.12122.

Kattari, Shanna K., Matthew Bakko, Hillary K. Hecht, and Leonardo Kattari. 2020. "Correlations between Healthcare Provider Interactions and Mental Health among Transgender and Nonbinary Adults." *SSM: Population Health* 10:100525. doi: 10.1016/j.ssmph.2019.100525.

Kcomt, Luisa, Kevin M. Gorey, Betty J. Barrett, and Esteban M. Sean. 2020. "Healthcare Avoidance Due to Anticipated Discrimination Among Transgender People: A Call to Create Trans-Affirmative Environments." *SSM: Population Health* 11:100608. doi: 10.1016/j.ssmph.2020.100608.

Mccrone, Sarah. 2018. "LBGT Healthcare Disparities, Discrimination, and Societal Stigma: The Mental and Physical Health Risks Related to Sexual and/or Gender Minority Status." *American Journal of Medical Research* 5(1):91-96. doi: 10.22381/AJMR5120189.

Meyer, Holly. 2016. “Counseling Debate Continues with New Tennessee Bill.” *The Tennessean.* Retrieved November 9, 2020, from (https://www.tennessean.com/story/news/politics/2016/12/07/counseling-debate-continues-new-tennessee-bill/95039534/).

Meyers, Laurie. 2016. “License to Deny Services.” *Counseling Today*. Retrieved October 14, 2021, from (https://ct.counseling.org/2016/06/license-deny-services/).

Mizrachi, Nissim, Judith T. Shuval, and Sky Gross. 2005. "Boundary at Work: Alternative Medicine in Biomedical Settings." *Sociology of Health and Illness* 27(1):20-43. doi: 10.1111/j.1467-9566.2005.00430.x.

Namaste, Viviane. 1996. “’Tragic Misreadings’: Queer Theory’s Erasure of Transgender Subjectivity.” Pp. 183–203 in *Queer Studies: A Lesbian, Gay, Bisexual, and Transgender Anthology,* edited by G. Beemyn and M. Eliason. New York: NYU Press.

Norris, Pauline. 2001. "How 'We' are Different from 'Them': Occupational Boundary Maintenance in the Treatment of Musculo-Skeletal Problems." *Sociology of Health and Illness* 23(1):24-43. doi: 10.1111/1467-9566.00239.

Ponton, Richard F., and Jill D. Duba. 2009. "The ACA Code of Ethics: Articulating Counseling's Professional Covenant." *Journal of Counseling & Development* 87(1):117-121. (https://ezproxy.mtsu.edu/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=104323915&site=eds-live&scope=site).

Puckett, Jae A., Meredith R. Maroney, Lauren P. Wadsworth, Brian Mustanski, and Michael E. Newcomb. 2020. "Coping with Discrimination: The Insidious Effects of Gender Minority Stigma on Depression and Anxiety in Transgender Individuals." *Journal of Clinical Psychology* 76(1):176-194. doi: 10.1002/jclp.22865.

Raymond, Janice. 1979. *The Transsexual Empire: The Making of the She-Male*. Boston: Beacon.

Romanelli, Meghan, and Michael A. Lindsey. 2020. "Patterns of Healthcare Discrimination among Transgender Help-Seekers." *American Journal of Preventive Medicine* 58(4):e123-e131. doi: 10.1016/j.amepre.2019.11.002.

Rubin, Henry S. 1999. “Trans Studies: Between A Metaphysics of Presence and Absence.” Pp. 173-92 in *Reclaiming Genders: Transsexual Grammars at the Fin de Si`ecle*, edited by K. More and S. Whittle. New York: Cassell.

Schilt, Kristen and Danya Lagos. 2017. "The Development of Transgender Studies in Sociology." *Annual Review of Sociology* 43:425-43. doi: 10.1146/annurev-soc-060116-053348.

Scott, John, ed. 2014. *Oxford Dictionary of Sociology*. Oxford: Oxford University Press.

shuster, stef. 2020. "Carving Out a Niche or Finding a Place at the Table? The Sociology of Transgender Studies." *Contemporary Sociology: A Journal of Reviews* 49(1):2-9. doi: 10.1177/0094306119889961.

Spade, Dean. 2015. *Normal Life: Administrative Violence, Critical Trans Politics, and the Limits of the Law.* Durham: Duke University Press.

Tennessee General Assembly. “HB 1840, SB 1556.” Retrieved November 9, 2020, from (http://wapp.capitol.tn.gov/apps/Billinfo/default.aspx?BillNumber=HB1840&ga=109).

Thomas, David R. 2006. "A General Inductive Approach for Analyzing Qualitative Evaluation Data." *American Journal of Evaluation* 27(2):237-246. doi: 10.1177/1098214005283748.

Wagner, Phil E., Adrianne Kunkel, Mary B. Asbury, and Frances Soto. 2016. "Health (Trans)Gressions: Identity and Stigma Management in Trans* Healthcare Support Seeking." *Women & Language* 39(1):49-74. (https://ezproxy.mtsu.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=ufh&AN=120565637&site=eds-live&scope=site).

Walsh, David. 2016. “Religious Counseling Bill Passes House Health Committee.” *Williamson Home Page*. Retrieved October 14, 2021, from (https://www.williamsonhomepage.com/news/religious-counseling-bill-passes-house-health-committee/article_5b7c1725-36dd-5196-a2d0-720a6d92470d.html).

APPENDICES

Appendix A: Demographics

Table 1. Demographics

Name	Gender Identity	Sexual Orientation	Age	Race/ Ethnicity	Political Party	Political Ideology	Religion
A	Transgender, Non-Binary	Bisexual, Pansexual	35	White	Leftist, Anarchafeminist, Communist	Very Liberal	Unaffiliated
B	Cisgender Woman	Prefer not to answer	25	White	Independent	Very Liberal	Unaffiliated
C	Cisgender Woman	Homosexual, Bisexual, Polysexual	33	White	Democrat	Very Liberal	Agnostic
D	Cisgender Woman	Pansexual	33	White	Democrat	Very Liberal	Atheist
E	Cisgender Woman	Bisexual	31	White	Leftist	Very Liberal	Unaffiliated
F	Cisgender Woman	Heterosexual	47	White	Other (not specified)	Prefer not to answer	Unaffiliated
G	Cisgender Woman	Queer	34	White	Independent	Very Liberal	Atheist
H	Cisgender Woman	Queer	40	White	Independent	Very Liberal	Spiritual
I	Cisgender Woman	Heterosexual	41	White	Democrat	Somewhat Liberal	Protestant
J	Cisgender Woman	Heterosexual	42	White	Republican	Somewhat Conservative	Christian
K	Transgender, Non-binary	Bisexual, Pansexual	40	White	Democrat	Somewhat Liberal	Unaffiliated
L	Cisgender Woman	Heterosexual	38	White	Democrat	Somewhat Liberal	Catholic
M	Cisgender Woman	Heterosexual	33	White	Generally Liberal, Not a fan of political parties	Somewhat Liberal	Agnostic Humanist
N	Cisgender Woman	Queer	32	Caucasian Jew	Democrat	Very Liberal	Agnostic and Spiritual
O	Cisgender Woman, Questioning	Bisexual, Demisexual	31	White	Democrat	Somewhat Liberal	Protestant
P	Cisgender Woman	Heterosexual	43	Black or African American	Democrat	Somewhat Liberal	Protestant
Q	Cisgender Woman		38	White	Politically Houseless	Somewhat Liberal	Spiritual

Appendix B: IRB Approval

IRB
INSTITUTIONAL REVIEW BOARD
Office of Research Compliance,
010A Sam Ingram Building,
2269 Middle Tennessee Blvd
Murfreesboro, TN 37129
FWA: 00005331/IRB Regn.. 0003571

MIDDLE TENNESSEE STATE UNIVERSITY

IRBN007 – EXEMPTION DETERMINATION NOTICE

Friday, September 10, 2021

Protocol Title	***Mental Health Providers' Perceptions of Tennessee Therapy Law***
Protocol ID	**21-1162 2q**
Principal Investigator	**Sally Warren** (Student)
Faculty Advisor	Adelle Dora Monteblanco
Co-Investigators	NONE
Investigator Email(s)	*sew6m@mtmail.mtsu.edu; adelle.monteblanco@mtsu.edu*
Department/Affiliation	Sociology & Anthropology

Dear Investigator(s),

The above identified research proposal has been reviewed by the MTSU Institutional Review Board (IRB) through the **EXEMPT** review mechanism under 45 CFR 46.101(b)(2) within the research category ***(2) Educational Tests, surveys, interviews or observations of public behavior*** *(Qualtrics Survey)*. A summary of the IRB action and other particulars of this protocol are shown below:

IRB Action	**EXEMPT from further IRB Review** Exempt from further continuing review but other oversight requirements apply
Date of Expiration	**6/30/2023** *Date of Approval:* **4/28/21** *Recent Amendment:* **9/10/21**
Sample Size	FIFTY (50)
Participant Pool	**Healthy adults (18 or older) - Currently practicing mental health professionals**
Exceptions	Online consent followed by internet-based survey using Qualtrics is permitted (Qualtrics links on file).
Type of Interaction	☐ Non-interventional or Data Analysis ☒ Virtual/Remote/Online Interview/survey ☐ In person or physical– Mandatory COVID-19 Management (refer next page)
Mandatory Restrictions	**1. All restrictions for exemption apply.** **2. The participants must be 18 years or older.** **3. Mandatory ACTIVE informed consent. Identifiable information including, names, addresses, voice/video data, must not be obtained.** **4. NOT approved for in-person data collection.**
Approved IRB Templates	*IRB Templates:* Online Informed Consent and Recruitment Email *Non-MTSU Templates:* Social Media Image
Research Inducement	NONE
Comments	NONE

Summary of the Post-approval Requirements: The PI and FA must read and abide by the post-approval conditions (Refer "*Quick Links*" in the bottom):

- ***Final Report:*** The Faculty Advisor (FA) is responsible for submitting a final report to close-out this protocol before **6/30/2023**; if more time is needed to complete the data collection, the FA must request an extension by email. REMINDERS WILL NOT BE SENT. **Failure to close-out (or request extension) may result in penalties** including cancellation of the data collected using this protocol or withholding student diploma.
- ***Protocol Amendments***: IRB approval must be obtained for all types of amendments, such as:
  - Addition/removal of subject population and sample size.
  - Change in investigators.
  - Changes to the research sites – appropriate permission letter(s) from may be needed.
  - Alternation to funding.
  - Amendments must be clearly described in an addendum request form submitted by the FA.
  - The proposed change must be consistent with the approved protocol and they must comply with exemption requirements.
- ***Reporting Adverse Events:*** Research-related injuries to the participants and other events , such as, deviations & misconduct, must be reported within 48 hours of such events to compliance@mtsu.edu.
- ***Research Participant Compensation:*** Compensation for research participation must be awarded as proposed in Chapter 6 of the Exempt protocol. The documentation of the monetary compensation must Appendix J and MUST NOT include protocol details when reporting to the MTSU Business Office.
- ***COVID-19:*** Regardless whether this study poses a threat to the participants or not, refer to the COVID-19 Management section for important information for the FA.

COVID-19 Management:
The FA must enforce social distancing guidelines and other practices to avoid viral exposure to the participants and other workers when physical contact with the subjects is made during the study.

- The study must be stopped if a participant or an investigator should test positive for COVID-19 within 14 days of the research interaction. This must be reported to the IRB as an "adverse event."
- The FA must enforce the MTSU's "Return-to-work" questionnaire found in Pipeline must be filled and signed by the investigators on the day of the research interaction prior to physical contact.
- PPE must be worn if the participant would be within 6 feet from the each other or with an investigator.
- Physical surfaces that will come in contact with the participants must be sanitized between use
- **FA's Responsibility:** The FA is given the administrative authority to make emergency changes to protect the wellbeing of the participants and student researchers during the COVID-19 pandemic. However, the FA must notify the IRB after such changes have been made. The IRB will audit the changes at a later date and the PI will be instructed to carryout remedial measures if needed.

Post-approval Protocol Amendments:
The current MTSU IRB policies allow the investigators to implement minor and significant amendments that would not result in the cancellation of the protocol's eligibility for exemption. ***Only THREE procedural amendments will be entertained per year*** *(changes like addition/removal of research personnel are not restricted by this rule).*

Date	Amendment(s)	IRB Comments
09/10/2021	A social media flyer image is approved. The image is not in MTSU format; the amendment request is approved however because the target population consists of professionals in the field.	IRBA2022-282

Post-approval IRB Actions:
The following actions are done subsequent to the approval of this protocol on request by the PI or on recommendation by the IRB or by both.

Date	IRB Action(s)	IRB Comments
NONE	NONE.	NONE

Mandatory Data Storage Requirement:
All research-related records (signed consent forms, investigator training and etc.) must be retained by the PI or the faculty advisor (if the PI is a student) at the secure location mentioned in the protocol

application. The data must be stored for at least three (3) years after the study is closed. Additionally, the Tennessee State data retention requirement may apply (*refer "Quick Links" below for policy 129*). Subsequently, the data may be destroyed in a manner that maintains confidentiality and anonymity of the research subjects. **The IRB reserves the right to modify/update the approval criteria or change/cancel the terms listed in this notice**. Be advised that IRB also reserves the right to inspect or audit your records if needed.

Sincerely,

Institutional Review Board
Middle Tennessee State University

Quick Links:

- Post-approval Responsibilities: http://www.mtsu.edu/irb/FAQ/PostApprovalResponsibilities.php
- Exemption Procedures: https://mtsu.edu/irb/ExemptPaperWork.php
- MTSU Policy 129: Records retention & Disposal: https://www.mtsu.edu/policies/general/129.php