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PEER-REVIEWED ARTICLE

Firearms in clients' homes: Role of clinical mental health counselors' political beliefs and treatment objectives

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ABSTRACT

A large body of research has pointed to the potential impact of clinical mental health counselors' (CMHCs) personal, social, and religious beliefs on their treatment objectives, but no research has examined the role of CMHCs' political beliefs on their treatment objectives, especially with politicized issues such as firearms in homes with young children. In the present study, we examined the treatment objectives for clients with firearms at home in relation to American CMHCs' political beliefs (operationalized as political ideologies and political party affiliations), perceived level of seriousness of firearm storage in a home with small children, and general assessment of biopsychosocial status of new clients. Survey data were collected with Qualtrics from 147 licensed CMHCs who were members of the American Mental Health Counselors Association (AMHCA). Perceived seriousness of firearms at home and treatment objectives related to firearms at home (e.g., discouraging firearm storage at home) were assessed using a vignette depicting a 38-year-old male client with two small children at home. General assessment of biopsychosocial status of new clients was measured with the frequency that the CMHC would inquire about 10 topics (e.g., substance use) during the initial appointment with new clients. Hierarchical regression analyses revealed that perceived seriousness of firearms at home and general assessment of biopsychosocial assessment were the most robust and expected predictors of the American CMHCs' treatment objectives. However, the CMHCs' political ideologies and political party affiliations were not significant, suggesting that CMHCs' clinical interactions with the client were guided by professional training/experiences, not by political beliefs.

KEYWORDS: treatment objective; firearm storage; CMHC; political beliefs

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INTRODUCTION

In the United States, deaths and injuries related to firearms in the home are a major public health concern (Grossman et al., 2005; Pallin et al., 2019). Helping professionals such as physicians and counselors can play an important role in reducing the impact of the crisis (Abdallah & Kaufman, 2021; Slovak & Brewer, 2010; Stanley et al., 2017). Because firearms in the home is a politically charged issue (Cone et al., 2021), the role of helping professionals' political beliefs in their clinical interactions with clients who are firearm owners is a worthy topic to investigate. Research on mental health practitioners' political beliefs may inform best practice, especially when related to politically sensitive issues (Bilgrave & Deluty, 2002; LaMothe, 2012). In this study, we sought to investigate the relationship between clinical mental health counselors' political beliefs and their treatment objectives for clients with young children who store firearms at home.

LITERATURE REVIEW

Clinical mental health counseling is defined as 'The provision of professional counseling services … to individuals, couples, families and groups, for the purpose of promoting optimal mental health, dealing with normal problems of living and treating psychopathology' (American Mental Health Counselors Association [AMHCA], 2021, p. 1). Clinical mental health counselors (CMHCs) are counselors who specialize in clinical mental health counseling. Because personal, social, and religious values and beliefs of mental health professionals (including CMHCs) influence their interactions with clients (Barrett & McWhirter, 2002; Blair, 2015; Bloom et al., 2016; Parikh et al., 2011), the AMHCA's ethical code emphasizes the importance of counselors' self-awareness of how these attributes may impact the clients (AMHCA, 2020). Extensive research has unveiled a relationship between mental health professionals' personal, social, and religious beliefs and their interactions and approaches with clients (Bilgrave & Deluty, 2002; Blair, 2015; Cummings et al., 2014; Morrison & Borgen, 2010; Shafranske & Malony, 1990). Several studies have specifically examined relationships between religious beliefs of mental health professionals and their interactions with clients. For example, most psychologists in two studies conducted by Bilgrave and Deluty (1998, 2002) reported that their religious beliefs moderately or significantly influenced their practice of therapy. In a review of 29 studies, Cummings et al. (2014) found a relationship between therapists' religious and spiritual beliefs and their attitudes about incorporating religion and spirituality in therapy. A meta-analysis by Walker et al. (2004) concluded that most therapists viewed religion and spirituality as relevant in their lives even though they rarely participated in organized religion.

Mental health professionals' political beliefs also influence their practice (Bilgrave & Deluty, 2002; Norton & Tan, 2019; Solomonov & Barber, 2019). Notably, though, mental health professionals, including CMHCs, are more likely to identify as liberals than

conservatives and as Democrats than Republicans (Norton & Tan, 2019; Parikh et al., 2011; Steele et al., 2014). Compared to the general US population, mental health professionals are less Republican, more Democratic, more likely to report no affiliation with a political party (i.e., more independent), more liberal, less moderate, and less conservative. To date, two studies have examined the relationship between the political beliefs of mental health professionals and their preferred counseling theories. The first was conducted by Bilgrave and Deluty (2002) among 282 mental health professionals sampled from the Clinical, Counseling, Psychotherapy, Humanistic, and Psychoanalysis divisions of the American Psychological Association (APA), finding that (1) liberalism, Eastern-mysticism, atheist/agnostic beliefs, and belief in science predicted commitment to humanistic counseling theory; (2) political conservatism did not predict adherence to cognitive–behavioral theory, though age (i.e., younger age), conservative Christianity, and higher belief in science did; and (3) liberalism predicted commitment to psychodynamic theory, along with older age, being female, and lower agreement with Eastern and mystical religious beliefs. The second study was conducted by Norton and Tan (2019), who surveyed 467 licensed mental health counselors in the USA on political ideology and preference for different counseling theory categories (e.g., cognitive–behavioral, psychodynamic–psychoanalytic), finding a relationship between political ideology and preferred counseling theory. These studies, however, did not examine the relationship between political ideology and selected treatment objectives for politicized issues such as firearm storage in homes with young children. Given that the combination of mental health crises and firearm access at home increases risk for injury and death (Simonetti et al., 2015), this gap in the research should be filled.

Due to the lack of research on this topic among counseling professionals, we examined a study by Hersh and Goldenberg (2016) on the relationship between health care providers' political beliefs and their treatment decisions in order to provide a context for the present study. Hersh and Goldenberg (2016) recruited 233 primary care physicians (PCPs) from the 29 US states that provide public listings of the political party affiliations of registered voters. They identified a pool of potential participants whose voter registration records indicated that they were either Democrats or Republicans and mailed them a survey that asked about their political ideology (i.e., very liberal, liberal, moderate, conservative, very conservative, or not sure), general assessment of biopsychosocial status, perceptions of seriousness of different case vignettes, and probability of certain treatment decisions. They concluded that there was no relationship between political party affiliation and treatment decisions on non-politicized issues. However, Republican PCPs were more likely to encourage safe storage of firearms, whereas Democratic PCPs were more likely to discourage the patient from storing firearms anywhere in the home (Hersh & Goldenberg, 2016). Essentially, political beliefs influenced primary care physicians' treatment approaches related to politically sensitive issues, begging the question of whether the same might be true for other healthcare practitioners, including CMHCs.

Collectively, mental health professionals, including CMHCs, are more politically homogenous than the general population and are over-represented by females (e.g., Bilgrave & Deluty, 2002; Norton & Tan, 2019; Parikh et al., 2011; Parikh et al., 2013; Solomonov & Barber, 2019; Steele et al., 2014). To date, no studies have examined the relationship between the political beliefs of CMHCs and their treatment objectives. Based on findings that CMHCs' beliefs influence their practices and that there is a relationship between physicians' political beliefs and treatment decisions on politically sensitive issues, we hypothesized that CMHCs' political beliefs would predict their treatment objectives in the current study.

METHOD

Research Design

In designing our study (IRB#pro00042191), a clinical vignette was used to gather data on the participants' treatment objectives and perceived seriousness of firearms at home. We adopted the vignette from the study by Hersh and Goldenberg (2016) among primary care physicians.

Participants

For our study, CMHCs were operationally defined as active members of AMHCA who were licensed as counselors in one or more states in the United States. To recruit participants, we utilized the AMHCA membership database. AMHCA has approximately 5,600 members and is the largest national association that exclusively represents American CMHCs. To qualify, the participants had to have a current and active license to practice. The recruitment information was posted on AMHCA's community forum from December 6, 2019 to January 19, 2020 and reminder messages were posted one and two weeks after the initial call for participation. Those who were interested in the study were asked to access the posted survey link hosted by Qualtrics. Participation was completely voluntary, and no compensation was offered. In total, completed or partially completed surveys were obtained from 168 AMHCA members but 21 participants did not answer questions about their political ideology and political party affiliation. As a result, usable data were available for 147 participants who were from 38 of the 50 US states.

Measures

Prior to data collection, we established face and content validity for key parts of our data collection measures (i.e., a clinical vignette and a rating scale) with three counselor educators with expertise in both clinical mental health counseling practice and research. Specifically,

they reviewed both the original survey used in Hersh and Goldenberg's (2016) study and the revised survey to be used in the current study and indicated a close fit between the two.

Outcome/Dependent Variable

In our study, the CMHCs' treatment objectives were treated as the outcome variable. As indicated above, they were adapted from Hersh and Goldenberg's (2016) study with PCPs but with slight modifications in verbiage such that items were more applicable to CMHCs. Specifically, the term 'patient' was replaced with 'client', the term 'physical checkup' was replaced with 'initial interview'. Three items were used to construct the treatment objectives related to the issue of firearm storage at home. Specifically, following the vignette, the participants responded how likely they would (1 = *definitely would not* to 10 = *definitely would*) take the following steps: (1) asking the client about firearm storage practices, (2) discussing risks of firearms in the home with the client, and (3) urging the client not to store firearms in the home. The internal consistency was adequate (α = .70). The sum of the three item ratings was used in data analysis. A higher sum indicated a stronger likelihood that the participant saw firearms in the home as an issue that required intervention.

Independent Variables

In our study, we focused on the participants' general inquiry related to client care, perceived seriousness of firearms at home, and political beliefs.

General Assessment of Biopsychosocial Status

The participants were first asked to respond to how often (1 = *never* to 5 = *always*) they would inquire, per the policy of their practice or their own preference, about the status of the following 10 areas upon meeting a new client: employment history, family history, hobbies, alcohol use, marijuana use, other recreational drug use, tobacco use, access to/use of firearms, sexual behavior, and exercise. In our study, this measure was used to capture the participant's general approach in assessing a new client's biopsychosocial status. The internal consistency of this scale was high (α = .86). The mean of the item ratings was used in data analysis. A higher score indicates that the participant conducted general biopsychosocial status assessment more frequently.

Perceived Seriousness of Firearm Storage Issue

Within the field of counseling, treatment decisions are informed by the counselor's clinical experiences (Stewart & Chambless, 2007). In our study, data for the counselor's clinical

experiences were obtained with a vignette describing a 38-year-old man who had two small children at home, had several firearms in the house, and who presented for an initial appointment with the counselor. Following the vignette, the participants were asked to respond to the question 'How serious of a problem do you think the issue is?' (1 = *not at all serious* to 10 = *very serious*).

Political Ideology and Party Affiliation

We operationalized political beliefs of American CMHCs as political ideology and party affiliation. The participants were asked to identify their political ideology as libertarian, conservative, liberal, socialist, communist, or other. Participants were also asked to identify which political party they were currently registered with using the nine major political parties (i.e., Constitution Party, Democratic Party, Democratic Socialists of America, Green Party, Independent Party, Libertarian Party, Reform Party, Republican Party, and Tea Party) identified by the American Democracy Project (American Association of State Colleges and Universities, 2022). Additional options of no party affiliation, not registered to vote, and unknown were also made available. In comparison to Hersh and Goldenberg's (2016) study, our study extended beyond Republican and Democrat categories to be inclusive of all political party memberships.

Covariates

We obtained data on the participants' age, gender, race/ethnicity, religiosity, and number of years in practice. Ethnicity options were identical to those used by the United States Census Bureau. Informed by the definition of religiosity by Bjarnason (2007), we asked the participants to report their religious affiliation and to report how important religion was to their everyday lives (1 = *very important* to 3 = *not important*). In data analysis, we used the participants' ratings of how important religion was to them. It was treated as a continuous variable, with a higher score indicating less importance.

Data Analysis Plan

Prior to data analysis, we checked all variables' distributions, and none showed abnormal distribution. Incomplete data were excluded from data analysis. For political ideology, we combined several categories into one 'Other' category because of a small number of responses in individual categories (e.g., Socialist). This resulted in four categories of political ideology (i.e., Liberal, Conservative, Libertarian, and Other). Similarly, we collapsed several categories of political party (e.g., those who were not registered to vote or had no party affiliation) into one 'No Party/Unregistered to Vote' category, resulting in four categories of

political parties (i.e., Democrat, Republican, Independent, and No Party/Unregistered to Vote). Finally, the participants' ages and their years in practice were highly correlated (r = .70, p < .001). To avoid collinearity, in data analysis we only included age.

To test our hypothesis that CMHCs' political beliefs would impact their treatment objectives, we ran two parallel hierarchical regression analyses. The first one was focused on the participants' political ideology, while the second one was focused on the participants' political party affiliation. We entered the variables into the regression model in three separate blocks: political background (either political ideology or political party affiliation) (Block 1), general assessment of biopsychosocial status and perceived seriousness of firearms at home (Block 2), and demographic background (Block 3). Model 1 of the regression only included Block 1, while Model 2 included Block 1 and Block 2, and Model 3 included all three blocks.

RESULTS

Descriptive Statistics

As shown in Table 1, there were more females than males and more Democrats than Republicans in the sample. On average, the participants were in their 50s and had been in practice for approximately 16 years. As a group, the participants perceived religion as somewhat important in their lives (1 = *very important*, 2 = *somewhat important*, 3 = *not important*). In terms of their general inquiry with working with new clients, the participants scored relatively high (M = 4.20, SD = 0.56 on a 5-point scale), suggesting that they would inquire about the clients' behaviors in all 10 areas (e.g., substance use). In terms of how serious they perceived firearms at home, they scored 6.52 (SD = 2.71) on a 1–10-point scale. Finally, the participants scored 7.11 (SD = 2.10) on their treatment objectives on a 1–10-point scale.

Regression Analysis Results

Table 2 and Table 3 summarize the standardized coefficients of regression analyses of the CMHCs' treatment objectives on their political beliefs, general inquiry, perception of seriousness of firearms in the home, as well as demographic variables. We utilized the results from Model 3 to determine if our hypotheses were supported.

Table 1. ***Descriptive Statistics for Study Variables (N = 135–147)***

Variable	**Mean**	***SD***
Age	52.44	13.44
Years in practice	16.44	11.58
Importance of religion	2.01	0.89
General assessment of biopsychosocial status	4.20	0.56
Perceived seriousness of firearm at home	6.52	2.71
Treatment objectives	7.11	2.10
Gender	***N***	**%**
Male	42	28.60
Female	105	71.40
Ethnicity		
Hispanic or Latino	14	9.50
Non-Hispanic	133	90.50
Political Ideology		
Conservative	29	19.70
Liberal	75	51.00
Libertarian	11	7.50
Other	32	21.80
Political Party Registration		
Democratic party	69	46.90
Independent party	12	8.20
Republican party	26	17.70
No party/Unregistered to vote	44	29.90

Table 2. ***Regression Results of Treatment Decision/Objectives on Political Ideology***

	Model 1	**Model 2**	**Model 3**
Liberal	0.22*	0.03	-0.06
Libertarian	-0.11	-0.09	0
Other	0.04	-0.03	-0.07
Conservative	Ref. (0)	Ref. (0)	Ref. (0)
General assessment of biopsychosocial status		0.18**	0.19**
Perceived seriousness of firearms at home		0.53***	0.53***
Importance of religion			0.21*
Male			-0.15*
Female			Ref. (0)
Age			0.09
Hispanic			0.06
Non-Hispanic			Ref. (0)
F	**3.35***	**18.98*****	**12.92*****
R^2	**0.073**	**0.367**	**0.429**
R^2 change		**0.294**	**0.023**

*$p < .05$. **$p < .01$. ***$p < .001$.

Note: A higher score on treatment decision indicates a stronger likelihood that the participant saw firearms in the home as an issue that required intervention.

Table 3. ***Regression Results of Treatment Decision on Political Party Affiliation***

	Model 1	Model 2	Model 3
No party/unregistered to vote	0.06	0	-0.05
Democrat party	-0.08	-0.05	-0.08
Independent party	-0.20*	-0.12	-0.12
Republican party	Ref. (0)	Ref. (0)	Ref. (0)
General assessment of biopsychosocial status		0.16**	0.18**
Perceived seriousness of firearms at home		0.54***	0.50***
Importance of religion			0.16˜
Male			-0.15˜
Female			Ref. (0)
Age			0.09
Hispanic			0.07
Non-Hispanic			Ref. (0)
F	**2.36˜**	**30.54*** **	**14.18*** **
R^2	**0.060**	**0.392**	**0.437**
***R^2* change**		**0.332**	**0.026**

˜*p* < .10. **p* < .05. ***p* < .01. ****p* < .001.

Note: A higher score on treatment decision indicates a stronger likelihood that the participant saw firearms in the home as an issue that required intervention.

Political Ideology and Treatment Objectives

As shown in Table 2, when no other variables were included in the regression analysis (Model 1), liberal participants scored higher than conservative participants in their treatment objectives ($B = 0.22$, $p < .05$). However, the variables only accounted for 7.3% of the variance in treatment objectives. In Model 2, general assessment of bio-psychosocial status ($B = 0.18$, $p < .01$) and perceived seriousness of firearms in the household ($B = 0.53$, $p < .001$) both significantly predicted higher treatment objective scores. Adding the two variables into the model led variance accounted for by the variables to increase from 7.3% to 36.7% (a 29.4% increase). Finally, in Model 3, when the participants' demographic background variables were added to the regression, general assessment of biopsychosocial status ($B = 0.19$, $p < .01$), perceived seriousness of firearms in the house ($B = 0.53$, $p < .001$), importance of religion ($B = 0.21$, $p < .05$), and male participant ($B = .21$, $p < .05$) were significant. The model accounted for 42.9% of the variance in the participants' treatment objectives. Based on the results from Model 3, the participants' political ideology was unrelated to their treatment objectives. Thus, the results did not support our hypothesis that CMHCs' political ideology would impact their treatment decisions.

Political Party Affiliation and Treatment Objectives

As shown in Table 3, when no other variables were included in the regression analysis (Model 1), participants who registered as an independent scored lower than participants who were

Republicans in their treatment objectives (B = -0.20, $p < .05$). However, the variables only accounted for 6.0% of the variance in treatment objectives. In Model 2, general assessment of biopsychosocial status (B = 0.16, $p < .01$) and perceived seriousness of firearms at home (B = 0.54, $p < .001$) both significantly predicted higher treatment objective scores. Adding the two variables into the model led variance accounted for by the variables to increase from 6.0% to 39.2% (an increase of 33.2%). Finally, in Model 3, when the participants' demographic background variables were added to the regression, general assessment of biopsychosocial status (B = 0.18, $p < .01$) and perceived seriousness of firearms in the house (B = 0.50, $p < .001$) were significant, and importance of religion (B = 0.16, $p < .10$) and gender of the participant (B = -0.15, $p < .10$) were marginally significant. The model accounted for 43.7% of the variance in the participants' treatment objectives. Based on the results from Model 3, the participants' political party affiliation was unrelated to their treatment objectives. Thus, the results did not support our hypothesis.

Overall, the results showed that general assessment of biopsychosocial status and perceived seriousness of firearms at home were the most robust predictors of CMHCs' treatment objectives. However, the participants' gender and the importance of religion to the participants also affected their treatment objectives, but political beliefs did not play a significant role.

DISCUSSION

We believe this is the first study to test whether clinical mental health counselors' political beliefs mattered in their clinical services related to firearms at the client's home. Our study was informed by the study of Hersh and Goldenberg (2016) on the significant impact of primary care physicians' political beliefs on their treatment decisions with patients who reported firearms at home. Based on their findings, we hypothesized that a similar picture would emerge from data on CMHCs. Our study revealed several interesting findings.

First, we found no statistically significant relationship between political beliefs (i.e., political party registration or political ideology) and the CMHCs' scores on treatment objectives for firearms at home. Thus, this finding failed to support our hypothesis and contradicted results obtained from Hersh and Goldenberg (2016), who revealed statistically significant differences between Republican and Democratic PCPs on treatment decisions related to firearms at home. We speculate that differences in the two professions' codes of ethics likely play a role in different findings from research on counselors and research on physicians. Specifically, the American Counseling Association (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), as does the AMHCA Code of Ethics (AMHCA, 2020). Conversely, the American Medical Association (AMA) Code of Medical Ethics allows and perhaps encourages physicians

to decline care to an existing patient when 'the patient requests care that is incompatible with the physician's deeply held personal, religious, or moral beliefs in keeping with ethics guidance on exercise of conscience' (AMA, n.d., p. 2). Accordingly, counseling training programs explicitly and specifically teach CMHCs to be aware of their biases, including political beliefs, to avoid imposing their beliefs on their clients, and to '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, 2014, p. 6). However, the American Medical Association's (AMA, 2014) Code of Ethics explicitly states that physicians are not ethically required to accept all prospective patients, although they should be thoughtful in exercising their right to choose whom to serve.

Second, we found that the CMHCs' gender and religiosity were significant predictors of their treatment objectives. Specifically, after controlling for other variables, male counselors scored significantly lower than female counselors on treatment objectives, suggesting that male counselors perceived firearms in the home as less of an issue needing intervention than did female counselors. Thus, although CMHCs are trained to stay neutral and not allow their personal views to influence their treatment approach, in reality, they do. Because CMHCs' gender is a fixed attribute that impacts the counselor's experiences in and out of clinical settings, it is conceivable that one's gender identity contributes to an intuitive and socially constructed way of knowing. Difference between male and female counselors in treatment objectives for firearms at home may be related to the social positions that females and males occupy in American society with respect to firearms. For instance, females are statistically much less likely than males to suffer firearm-related deaths, incidents, and accidents in the USA (Geier et al., 2017; Gollub & Gardner, 2019). Differences between adverse male and female experiences with firearms may be related to male CMHCs' perception of firearms-related issues as unpreventable and female CMHCs' perception of firearms-related issues as preventable. More research is needed to gain additional insights in gender difference in treatment objectives related to firearms at home.

The importance of recognizing one's religious beliefs when working with clients has been greatly emphasized in the field of counseling and psychotherapy (Dorre & Kinnier, 2006; Erford, 2015; Gladding & Newsome, 2018; Peteet et al., 2016; Shafranske & Cummings, 2013). Koenig (2013) specifically called upon counselors to be mindful of their religious beliefs in client care, although existing studies have rarely examined how counselors' religious beliefs, when involved in the counselors' decision-making, influenced their treatment objectives. A recent study by Duggal and Sriram (2021) has shown that therapists' religious beliefs were interwoven with choices of therapeutic techniques and theoretical orientation. Our finding that participants who reported that religion played a less important role in their lives more strongly endorsed treatment objectives related to firearm storage in a home with young children suggests that counselors' treatment objectives are indeed influenced, at least to some extent, by religion. We suspected that counselors who placed less emphasis on the

importance of religion in their own lives may hold a stronger belief that individuals have stronger control of their circumstances and thus should be more responsible for their actions. More research is needed to understand how religion affects counselors' clinical behaviors.

Third, and finally, CMHCs' general assessment of the client's biopsychosocial status and their perceived seriousness of firearm storage in a home with young children were the most robust factors, as expected, in affecting their treatment objectives in addressing firearms in a client's home with young children. This finding is not a surprise as it is consistent with the training and general practice in the field of counseling. Additionally, this finding also offers indirect evidence to the validity of our design. The fact that these two variables accounted for a large amount of the variance in the treatment objectives suggests that CMHCs depended heavily on insights from their professional views to guide their treatment.

Limitations

It is important to consider several limitations when interpreting the results of the study. First, the sample size was small, which made it difficult to conduct more sophisticated analyses on subgroups of participants. All CMHCs who participated in our study were members of AMHCA at the time of survey completion. There are approximately 140,760 CMHCs in the United States (Health Resources & Services Administration, 2020), but only about 5,600 are members of AMHCA. Because there could conceivably be differences between CMHCs who maintain membership at AMHCA and those who do not, it is difficult to know whether our findings are representative of the CMHC population in the USA or the AMHCA members.

A second limitation in our study involves the lack of utilization of an established measure for political ideology to supplement the self-reports. Such measures were excluded to prevent the survey from becoming so lengthy or time-consuming that busy clinicians might be less likely to complete the full survey. While our decision was based on research findings that this procedure accurately predicts voting behavior (Graham et al., 2009; Kanai et al., 2011), the construct of political beliefs could be more complex than party affiliation and political ideology as we measured it.

Additionally, like any study that relies on volunteers, 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 et al., 2017). It is thus unknown whether the findings reflect the experiences of other CMHCs.

Finally, while vignettes are commonly used in this type of research, CMHCs were aware that they were not making decisions in an organic clinical environment. The extent to which the results from the current study could generalize to 'real-world' clinical environments is unknown (Sheperis et al., 2017). Qualitative and/or mixed-methods studies may yield additional information about the impact of values, beliefs, and biases on clinical work. For

instance, more insights might be gained from qualitative data on how CMHCs of different political ideologies would respond to working with clients who arrive in the clinic with concealed weapons or visiting clients with and without guns in the home.

Implications

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, 2021, p. 1). 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. Because of the nature of their work, CMHCs are obligated by their ethics codes (e.g., ACA, 2014; AMHCA, 2020) to be aware of the impact of their beliefs and biases on their work and to avoid imposing their values on their clients. However, our finding that CMHCs' religiosity and gender mattered in their treatment objectives suggests that there is still work to be done in terms of reducing CMHC bias in counseling. Because these factors heavily affect one's worldview, intentional effort on the part of CMHCs is necessary to limit the impact of these factors on client care. We recommend that CMHCs work to identify how their worldview impacts their 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.

For decades, the field of mental health counseling has stressed the importance of recognition of counselor bias. The ethical codes of counseling associations (i.e., ACA, 2014; AMHCA, 2020) compel CMHCs to be aware of how their values, beliefs, and biases impact their work and to avoid imposing those beliefs on their clients. In the meantime, however, the counseling profession has been impacted by politics. For instance, 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. Thus, our finding that the participants' political ideology and political party affiliation were minimally related to their treatment objectives for a highly political issue may be an indication of progress in the profession's commitment to reducing bias in client care. In a politically charged and polarized climate, this finding is refreshing and reassuring. Nonetheless, it is unknown whether politics will begin to enter mental health counseling if/as American society becomes more polarized.

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Data availability

Data for this manuscript are available upon request.

Ethics approval

All aspects of the study were approved by the Institutional Review Board of the University of South Florida (IRB#pro00042191).

Informed consent

Consent was obtained by requesting the participant to check the appropriate statement prior to gaining access to the survey questions online.

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