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Navigation of Ethical Conflicts Among Religious Psychotherapists Treating Lesbian and Gay Patients

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Religious psychotherapists may experience an ethical conflict between their religious beliefs and recommended psychological practice when treating lesbian or gay patients. The aim of this study was to investigate how religious psychotherapists navigate clinical situations that present a conflict between their religious and professional ethics. Sixty religious psychotherapists completed measures of belief in, and adherence to, gay affirmative practice, attitudes toward lesbians and gay men, religious fundamentalism, and methods of navigating conflicts between religious beliefs and practice with lesbian and gay individuals. Greater religious fundamentalism was found to predict more negative attitudes toward lesbian and gay orientations, which in turn was found to predict decreased adherence to gay affirmative practice. Participants used a variety of methods to navigate conflicts between professional and religious ethics; however, compartmentalization and consultation with professional leaders were more commonly used than any other method. These findings refine those from previous research showing that religious affiliation was not associated with decreased adherence to gay affirmative practice. We found that although religious affiliation in general may not be associated with the use of gay affirmative practice, religious fundamentalism is, and this latter association is mediated by attitudes toward lesbian and gay orientations.

Keywords: LGBT, religion, fundamentalism, gay affirmative practice

As individuals who identify with two ethical systems, religious psychotherapists may encounter situations in which these systems are at odds with each other. Lesbian and gay orientations (LG orientations) can present such a conflict (Fallon et al., 2013; Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991; Priest & Wickel, 2011). This issue garnered popular attention in 1996, when a religious psychotherapist in Mississippi refused to counsel a female patient about her same-sex relationship with another woman. The psychotherapist ended up suing her employer after being dismissed from her job. A federal court jury ruled that the psychotherapist had been a victim of religious discrimination, because her employer had not accommodated her religious beliefs. This ruling was reversed by a U.S. Court of Appeals, because by refusing to treat lesbian and gay patients, the psychotherapist would have unduly burdened her colleagues and might have prevented lesbian and gay clients from receiving the services they required (Herlihy, Hermann, & Greden, 2014; Priest & Wickel, 2011).

Although a limited number of articles have sought to help religious psychotherapists deal with such conflicts (e.g., Fallon et al., 2013), no published research has assessed what methods such therapists typically use to negotiate conflicts they encounter between religious and professional ethical systems. Moreover, virtually no research has looked at whether such therapists are in fact able to provide ethical psychotherapy to gay and lesbian patients. One aim of the present study is to begin filling in these gaps in the literature.

In 2012, the American Psychological Association issued *Guidelines for Psychological Practice With Lesbian, Gay, and Bisexual Cli-*

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ents. Broadly speaking, these guidelines stated that psychologists should strive to understand the experiences of lesbian, gay, and bisexual patients and should consider the orientations of these patients as normal forms of human sexuality rather than mental illness. These guidelines identified areas of competency for working with lesbian, gay, and bisexual individuals, including knowledge of (a) human sexuality (of all orientations) across the life span; (b) how social stigma impacts the development of sexual orientation and identity; (c) how demographic variables, such as age, gender, ethnicity, religion, and socioeconomic status, affect the coming out process; (d) the dynamics of same-sex relationships; (e) the dynamics of lesbian, gay, and bisexual individuals' relationships with their families of origin; (f) how lesbian, gay, or bisexual orientation affects one's spiritual orientation and affiliation with religious groups; (g) discrimination at work; and (h) coping strategies for lesbian, gay, and bisexual individuals.

Gay affirmative practice has been increasingly accepted as the most culturally competent model for psychotherapy with gay, lesbian, and bisexual patients (Crisp, 2006). This treatment approach affirms that gay, lesbian, or bisexual orientations are as positive an expression of human experience as is a heterosexual orientation (Davies, 1996). Gay affirmative practice requires that the practitioner actively validate patients' sexual identity in order to allow them to confront any of their own negative feelings toward their sexuality, and contribute to the healthy development of a gay, lesbian, or bisexual identity (Crisp, 2006).

More specifically, gay affirmative practice involves (a) not assuming the patient is heterosexual; (b) viewing discrimination against lesbian or gay individuals, and not lesbian or gay identify, as problematic; (c) viewing a nonheterosexual identity as a positive result of treatment; (d) working to minimize the patient's own negative feelings about being lesbian or gay; (e) being knowledgeable about the social policies affecting lesbian and gay individuals and about the coming out process; and (f) dealing with one's own biases (Appleby & Anastas, 1998; Crisp, 2006; Crisp & DiNitto, 2004). Negative attitudes toward lesbian and gay individuals have been found to be negatively correlated with adherence to gay affirmative practice (Crisp, 2007).

Numerous studies have demonstrated an association between various dimensions of religiosity and attitudes toward LG orientations (Crisp, 2007; Gentry, 1987; Herek, 1987; Johnson, Brems, & Alford-Keating, 1997; Kunkel & Temple, 1992; Maret, 1984; Seltzer, 1992). The most common limitation to these studies is the use of measures of religiosity with no demonstrated validity. In addition, inconsistencies in how religiosity and attitudes toward LG orientations have been assessed across studies have limited the degree to which results can be compared. For example, an early study by Maret (1984) evaluated the association between religious fundamentalism and attitudes toward LG orientations using single-item, binary self-report measures of both fundamentalism and attitudes toward LG orientations (i.e., participants were asked whether they approved of LG orientations and whether they were fundamentalist). This study thus failed to assess attitudes toward particular aspects of homosexuality, and failed to distinguish among levels of fundamentalism.

A subsequent study (Herek, 1987) investigated the association between religiosity and attitudes toward LG orientations using an almost entirely Christian sample (all but four participants), measuring religiosity using the Religious Ideology Scale (RIS; adapted from Putney & Middleton, 1961), a measure of adherence to fundamentalist Christian beliefs. Higher scores on the RIS were associated with more negative attitudes toward LG orientations; however, both the religious homogeneity of the sample and the specificity of the scale limited the generalizability of that finding.

Several other studies that have demonstrated an association between religiosity and negative attitudes toward LG orientations were similarly limited by their homogeneous sample and their operationalization of religiosity. Two had entirely Christian samples (Kunkel & Temple, 1992; Seltzer, 1992). One Tulane University study (Gentry, 1987) had no Muslim participants and, given the demographics of the population at the university, participation by Orthodox Jews was also unlikely. All three studies gauged religiosity on the basis of participation in religious services, which may or may not reflect identification with a religion's beliefs or ethical system.

Two studies have obtained similar findings using more meaningful measures of religiosity that gauge religious beliefs and adherence to those beliefs (Johnson et al., 1997; Whitley, 2009). Furthermore, a meta-analysis of the research on this topic has revealed that various forms of religiosity, including attendance at services, orthodoxy, fundamentalism, and self-reported religiosity, are, to varying degrees, all associated with negative attitudes toward lesbian and gay individuals (Whitley, 2009). Thus, despite the limitations of the literature on this topic, there is evidence for an association between religiosity and negative attitudes toward LG orientations.

Given this association, it seems plausible that a religious psychotherapist whose religion views LG orientations negatively would be less able to function as a gay affirmative psychotherapist for gay and lesbian patients. Although the empirical research on this question is limited, one study (Crisp, 2007) assessed religiosity, attitudes toward gay and lesbian individuals, and gay affirmative practice among social workers. This study investigated whether or not participants were religiously affiliated, and with what religion, but did not assess the degree of their religiosity. Participants with Protestant and Catholic religious affiliations had significantly more negative attitudes toward gay and lesbian individuals, but these attitudes did not affect their self-reported degree of adherence to gay affirmative practice. Crisp theorized that the participants might have adhered to gay affirmative therapy in spite of their attitudes and religious beliefs. This would indicate that these social workers faced a conflict between their religious and professional values but resolved that conflict in a manner more consistent with their professional than their religious beliefs.

Mental health professionals must integrate their personal and professional ethical systems as part of ethical clinical practice (Fallon et al., 2013; Handelsman, Gottlieb, & Knapp, 2005; Knapp, Handelsman, Gottlieb, & VandeCreek, 2013). The ethical acculturation model (EAM; Handelsman et al., 2005) uses the framework of immigrant acculturation to conceptualize how psychologists in training integrate professional ethics with their existing cultural and individual ethics. Within this conceptual framework, *assimilation* refers to adopting the new culture or ethical system in preference to the previously held one. In the case of religious psychotherapists treating lesbian or gay patients, assimilated therapists would opt for gay affirmative practice despite their religious beliefs. *Separation* refers to holding onto one's original culture or ethical system instead of adopting the new one. The separated therapist would adhere to his or her religious beliefs and would not adopt the standards of gay affirmative practice. *Marginalization* indicates losing one's original culture or ethical system while not adopting the new one. A marginalized therapist might reject both his or her original religious beliefs and the psychological standards regarding LG orientations. Finally, *integration* denotes adopting the new culture or ethical system while maintaining some parts of the original ones. The integrated psychotherapist maintains a religious identity while still adhering to gay affirmative practice.

Social identity complexity (Roccas & Brewer, 2002) is a broader theoretical framework for conceptualizing how individuals integrate multiple identities of any type, be it ethical, cultural, or otherwise. Within this framework, there are at least four distinct ways in which an individual might reconcile membership in multiple groups when establishing her or his own identity: intersection, dominance, compartmentalization, and merger. *Intersection* refers to identifying only with the overlap of the different groups. For example, a Black lesbian might not identify with all Black people or all lesbians, but rather only with Black lesbians. *Dominance* refers to identifying primarily with one group, while membership in other groups takes on lesser importance. A Christian Arab, for example, might identify primarily as a Christian, and less so as Arab. *Compartmentalization* refers to identifying with one group in certain contexts and another group in other contexts. A Hispanic Jew might identify as Hispanic at school but as Jewish at synagogue. Finally, *merger* refers to identifying with all groups of which one is a member. For instance, a Chinese Buddhist might identify both with other Chinese people and with other Buddhists. Which of these approaches an individual takes depends on personality factors, such as tolerance of ambiguity, as well as on situational factors, such as stress level.

The religious psychotherapist whose religious values include a negative view of LG orientations is an individual who is simultaneously a member of two groups with conflicting values. Applying the designations discussed above (intersection, dominance, compartmentalization, merger) to the religious psychotherapist yields four theoretical possibilities: (a) The psychotherapist may identify with both the religious and the professional values and feel bound by both, and such an individual may seek to avoid situations in which there is a conflict between religious and professional values, perhaps by referring out; (b) the psychotherapist may favor one set of values over the other, adhering to one at the expense of the other, by deciding, for example, that his or her professional values are more important than his or her religious values, or vice versa; (c) the psychotherapist may compartmentalize, which might entail adhering to professional values rather than religious ones when functioning as a psychotherapist; or (d) the psychotherapist may seek to integrate his or her religious and professional values, which might entail reinterpretation of the values to avoid conflicts between them. Each of these possibilities has different implications for the psychotherapist's adherence to gay affirmative practices.

The present study sought to investigate how religious psychotherapists navigate clinical situations that present a conflict between their religious and professional ethics. We hypothesized that (a) religious fundamentalism would predict attitudes toward lesbian and gay individuals, (b) religious fundamentalism would predict belief in and adherence to gay affirmative practice, (c) attitudes toward lesbian and gay individuals would predict belief in and adherence to gay affirmative practice, and (d) attitudes toward lesbian and gay individuals would mediate the relationship between religious fundamentalism and belief in and adherence to gay affirmative practice. Because societal attitudes toward lesbian and gay individuals have shifted over recent decades (Loftus, 2001), we controlled for years since licensure in the above analyses. Because research indicates there are gender differences in attitudes toward lesbian and gay individuals (Herek, 1988; Kite & Whitley, 1996; Kite, 1984), we also controlled for gender.

Method

Participants

Religious mental health professionals were approached directly by the authors and were asked to recruit other religious mental health professionals whom they knew. Mental health professionals who advertise themselves as religious were also directly contacted. Participants were also recruited through religious associations and organizations. The initial sample included 92 licensed practitioners who consented to participate in the research study. After excluding 32 participants for reasons to be described below, the final sample used for the study consisted of 60 religious mental health professionals from three religions and multiple professional fields. Demographic statistics for the sample are presented in Table 1.

Measures

Gay Affirmative Practice Scale. The Gay Affirmative Practice Scale (GAP; Crisp, 2006) was used to assess the extent to which participants' principles and behaviors are compatible with gay affirmative practice. This 30-item

Table 1
Demographic Statistics

Demographic variable	*N*	*M*	*SD*	%
Race				
Asian/Pacific Islander	3			5.0
White	57			95.0
Ethnicity				
Hispanic	1			1.7
Non-Hispanic	59			98.3
Gender				
Female	36			60.0
Male	24			40.0
Field				
Psychology	19			31.7
Social work	15			25.0
Medical	9			15.0
Other mental health	17			28.3
Degree				
Bachelor's	1			1.7
Master's	28			46.7
Doctoral	31			51.7
Years licensed	60	13.3	12.0	
Religion				
Christian	19			31.7
Jewish	36			60.0
Muslim	5			8.3

questionnaire is divided into two sections of equal length. In the first section, the belief domain, participants are asked to rate the extent to which they agree with statements about therapy with gay and lesbian clients, using a five-point Likert-type scale ranging from *Strongly Agree* to *Strongly Disagree*. In the second section, the behavior domain, participants are asked to assess the frequency with which they engage in listed behaviors with gay and lesbian clients, using a five-point Likert-type scale ranging from *Always* to *Never*. The scale demonstrated good internal consistency in our sample, with an overall Cronbach's alpha of .92 and .89 for the belief and behavior domains, respectively. The measure has demonstrated good factorial validity: confirmatory factor analysis with a two-factor solution revealed each item loading with its intended factor .60 or greater. The GAP has been found to be significantly and positively correlated to other measures of attitudes toward gay and lesbian individuals, and unrelated to social desirability (Crisp, 2006).

Attitudes Toward Lesbians and Gay Men Scale. The Attitudes Toward Lesbians and Gay Men Scale (ATLG; Herek, 1984) is a 20-item measure of the attitudes of heterosexuals toward lesbians and gay men. Each item is a statement about either lesbians or gay men, and respondents are asked to rank the extent to which they agree with that statement on a five-point Likert-type scale ranging from *Strongly Disagree* to *Strongly Agree*. We used six of the items for the purposes of this study, three measuring attitudes toward lesbians, and three measuring attitudes toward gay men. The ATLG demonstrated good internal consistency in our sample, with Cronbach's alpha of .84. The ATLG has consistently demonstrated good construct validity; higher scores have positively correlated with measures of religiosity, belief in traditional gender roles, lack of contact with lesbian and gay individuals, endorsement of "traditional" family values, agreement with public policy that discriminates against sexual minorities, and stigma against people with AIDS (Herek, 1994, 2009; Herek & Capitanio, 1996, 1999a, 1999b).

Religious Fundamentalism Scale. The Religious Fundamentalism Scale (RFS; Altemeyer & Hunsberger, 1992) is a 12-item questionnaire that measures the extent to which respondents believe that their religion represents fundamental truths about humanity and deity. The RFS demonstrated good internal consistency in our sample, with Cronbach's alpha of .90. The RFS has good construct validity: Scores have positively correlated with right-wing authoritarianism, Christian orthodoxy, prejudice, hostility toward gay and lesbian individuals, likelihood of joining a "posse" to hunt down radicals, and likelihood of imposing sterner sentences in a trial (Altemeyer & Hunsberger, 1992).

Procedure

All participants completed the measures online. Participants were excluded if they did not complete at least two of the study's three psychometrically validated scales without omitting an excessive number of items, defined as three items of the ATLG, six items of the RFS, and eight items of the GAP.

Participants also completed a demographic questionnaire regarding their race, ethnicity, gender, field, degree, years licensed, and religious affiliation, as well as a questionnaire created for the purposes of this study composed of 13 items related to participants' experience of conflict between their religious and professional values, their experience treating lesbian and gay patients, their self-rated ability to avoid acting in a biased manner when treating lesbian and gay patients, and their engagement in various methods of navigating conflicts between religious and professional values. These items were assessed using a five-point Likert-type scale. Items were completed on a scale either from 1 (*Never*) to 5 (*Always*), or 1 (*Strongly Disagree*) to 5 (*Strongly Agree*). To safeguard anonymity, no identifying information was collected. No incentive was offered for participation.

Results

Results of all regression analyses are presented in Table 2. Descriptive statistics for items regarding methods used to navigate conflicts are presented in Table 3.

Hypothesis 1

Multiple regression confirmed our hypothesis that religious fundamentalism would predict

Table 2
Primary Analysis Using Hierarchical Multiple Regression

Hypothesis: dependent variable, step, and predictor variable	*B*	*SE*	ΔR^2
Hypothesis 1: ATLG			
Step 1			
Gender	.19	.43	.01
Years licensed	−.00	.01	
Step 2			
Gender	.05	.16	.57
Years licensed	.00	.01	
RFS	−1.17*	.13	
Hypothesis 2: GAP			
Step 1			
Gender	.32*	.15	.16
Years licensed	−.01*	.01	
Step 2			
Gender	.23	.13	.24
Years licensed	−.01	.01	
RFS	−.48*	.11	
Hypothesis 3: GAP			
Step 1			
Gender	.32*	.15	.16
Years licensed	−.01*	.01	
Step 2			
Gender	.24*	.11	.34
Years licensed	−.01*	.01	
ATLG	.36*	.06	
Hypothesis 4: GAP			
Step 1			
Gender	.32*	.15	.16
Years licensed	−.01*	.01	
Step 2			
Gender	.23	.13	.24
Years licensed	−.01	.01	
RFS	−.48*	.11	
Step 3			
Gender	.23*	.12	.11
Years licensed	−.01	.01	
RFS	−.11	.15	
ATLG	.31*	.10	

Note. ATLG = Attitudes Toward Lesbians and Gay Men Scale; RFS = Religious Fundamentalism Scale; GAP = Gay Affirmative Practice Scale.
* $p < .05$.

mental health professionals' attitudes toward gay and lesbian individuals, even after controlling for gender and years since licensure. Neither gender nor years since licensure predicted attitudes toward gay and lesbian individuals.

Hypothesis 2

The second hypothesis suggested religious fundamentalism would be a significant predictor of gay affirmative practice. This hypothesis was also confirmed by multiple regression. Gender and years since licensure were initially found to significantly predict gay affirmative practice; however, once religious fundamentalism was added to the model, these demographic factors were no longer significant.

Hypothesis 3

Multiple regression demonstrated that attitudes toward lesbians and gay individuals significantly predicted gay affirmative practice. Both gender and years since licensure also emerged as significant predictors of gay affirmative practice over ATLG, such that being a man and having been licensed longer both predicted lower levels of gay affirmative practice.

Table 3
Descriptive Statistics for Items Regarding Methods Used to Navigate Conflicts

Item	*M*	*SD*
Methods of handling conflict		
Consult with other professionals or seek professional supervision and/or do other forms of research into professional ethics	3.43*	1.04
Adhere to professional values at work and religious values otherwise (compartmentalize)	3.37	1.40
Consult with religious advisers and/or do other forms of research into religious ethics	3.09	1.19
Adhere to religious values over professional ones, in case of general conflict	2.88	1.34
Adhere to religious values over professional ones, in case of conflict regarding LG orientations	2.61	1.16
Try to refer the patient to another mental health professional, in case of general conflict	2.54	1.36
Inform lesbian and gay patients of bias and allow them to choose	2.32*	1.64
Try to refer the patient to another mental health professional, in case of conflict regarding LG orientations	1.98*	1.14
Avoid bias by avoiding the topic	1.80*	0.86
Encourage sexual orientation change therapy	1.41*	0.78
Related Issues		
Able to avoid bias when treating lesbian and gay patients	4.00*	0.79
Discomfort regarding conflict	3.43	1.08
Religious change resulting from conflict	2.26*	1.25

* significantly different from neutral ($p < .05$).

Hypothesis 4

We hypothesized that attitudes toward gay and lesbian individuals would serve as a mediating variable in the relationship between religious fundamentalism and gay affirmative practice. The preceding analyses demonstrated that religious fundamentalism was significantly associated with both attitudes toward gay and lesbian individuals and gay affirmative practice. We used a hierarchical multiple regression to examine gay affirmative practice as a function of religious fundamentalism and attitudes toward gay and lesbian individuals, while controlling for gender and years since licensure. Results indicated that when we introduced attitudes toward gay and lesbian individuals to the model, the association between religious fundamentalism and gay affirmative practice was no longer significant, but the association between attitudes toward gay and lesbian individuals and gay affirmative practice was significant, supporting our hypothesis that attitudes toward gay and lesbian individuals mediate the association between religious fundamentalism and gay affirmative practice. Both gender and years since licensure initially predicted gay affirmative practice at Step 1; however, once religious fundamentalism was added in Step 2, neither demographic variable remained significant. When attitudes toward gay and lesbian individuals were added at Step 3, gender reemerged as a significant predictor of gay affirmative practice.

Methods of Handling Conflict

Participants were asked to rate the extent to which they rely on various methods of handling conflicts between their religious and professional ethics regarding the treatment of lesbian and gay patients. These responses, in order of popularity, are presented in Table 3. They also answered questions about related issues.

Exploratory Analyses

For exploratory purposes, we used analysis of variance to investigate differences in religious fundamentalism, attitudes toward gay and lesbian individuals, and gay affirmative practice across demographic categories of gender, professional field, and degree (see Table 4). For the purpose of investigating differences among professional fields, participants were categorized into one of four groups, based on their licensed profession: (a) psychology; (b) social work; (c) medicine, including physicians and nurses; and (d) other master's-level providers. For the purpose of investigating differences across levels of degree, participants were categorized into one of three groups: (a) bachelor's degree, (b) master's-level degree, and (c) doctoral-level degree. Results of all exploratory analyses are presented in Table 4.

No differences in religious fundamentalism were found among participants from different professional fields; however, participants with doctoral degrees were significantly less funda-

Table 4
Exploratory Analyses: Religious Fundamentalism, Attitudes Toward Lesbian and Gay Individuals, and Gay Affirmative Practice by Profession and Degree

Variable	*N*	Religious fundamentalism		Attitudes toward lesbian and gay individuals		Gay affirmative practice	
		M	*SD*	*M*	*SD*	*M*	*SD*
Profession							
Psychology	19	2.92	0.65	3.37	0.89	3.81	0.44
Social work	15	3.19	0.56	2.71	0.82	3.95	0.73
Medical	9	2.83	0.53	3.28	0.77	3.68	0.47
Other master's providers	17	3.21	0.55	2.53	0.87	3.64	0.56
Degree							
Bachelor's	1	3.75		2.17		3.30	
Master's	28	3.26	0.50	2.55	0.77	3.74	0.65
Doctoral	31	2.85	0.60	3.34	0.87	3.81	0.55

mentalist than those with bachelor's or master's degrees. Significant differences in attitudes toward lesbian and gay individuals were found among participants from different professional fields. Specifically, individuals with a license in psychology had a more positive attitude than other master's-level providers. Individuals with a license in psychology also had more positive attitudes toward lesbian and gay individuals than did individuals from the other two professions, although these differences were not significant. Participants with doctoral-level degrees had significantly more positive attitudes toward lesbian and gay individuals than did participants with master's or bachelor's degrees. No differences in gay affirmative practice were found among participants from different professional fields or with different degrees.

Discussion

Our findings suggest that among Christian, Jewish, and Muslim religious adherents, greater religious fundamentalism predicts more negative attitudes toward LG orientations, which in turn predicts decreased adherence to gay affirmative practice. Although these findings seem intuitive, they refine previous findings that have shown that religious affiliation was not associated with decreased adherence to gay affirmative practice. Our findings suggest that although religious affiliation in general may not be associated with gay affirmative practice, among these religious groups, religious fundamentalism is, and this latter association is mediated by attitudes toward LG orientations. This finding is important, as it pertains to therapists' awareness of their own biases and competency in working with gay and lesbian patients, as well as to gay and lesbian patients' considerations when seeking a therapist.

The finding that more recently licensed therapists tended to adhere more to gay affirmative practice may reflect increasingly positive attitudes toward LG orientations in the field of mental health and in society in general. That psychologists had the most positive attitudes toward LG orientations of all the mental health professionals in our sample may be reflective of the training received by psychologists, the personalities of individuals who choose to study psychology, or the professional culture of the field. The finding that those with doctoral-level degrees tended to have more positive attitudes may have come about because higher levels of education or increased time spent in an academic setting may lead to more positive attitudes toward LG orientations, or because individuals who pursue higher education or choose to spend more time in an academic setting may tend to have had more positive attitudes to begin with.

With regard to how religious therapists navigate conflicts between their professional and religious ethics, our findings indicate that these individuals use a variety of methods, but that the most commonly used are compartmentalization and consultation with religious and professional mentors. Notably, though, participants indicated only a moderate identification with these strategies, on average indicating that they consult or do other forms of research "about half the time" and on average stating that they "neither agree nor disagree" with whether they tend to compartmentalize by following their professional values at work and their religious values the rest of the time. These findings may indicate that individuals tend not to have a proactive, thought-out approach to dealing with conflicts; alternatively, it may be that the method of dealing with such conflicts varied across participants, and that this is why there didn't seem to be one method that stood out as most common. It is noteworthy that participants tended not to encourage sexual orientation change therapy and tended not to think they could avoid bias by avoiding the topic of LG orientations. Overall, participants endorsed avoiding bias when treating lesbian and gay patients.

Awareness of the interaction between one's personal or religious ethics and one's professional ethics is essential to ethical practice as a mental health professional. An educational environment that values and respects multiculturalism is likely to facilitate such awareness by fostering openness and honesty about personal and religious ethics, even when these conflict with professional or mainstream ethics. Thus, aspiring mental health professionals should be encouraged not to exchange their personal ethical systems for a professional one, but to reflect on conflicts among their ethical systems and to proactively consider ethical ways of addressing these conflicts.

This study is limited in several ways. A primary limitation is that, although three religions were represented in the sample, the majority were Jewish; furthermore, the majority of the Jewish participants were Orthodox. Because different religious groups are likely to have different approaches to navigating the interaction of their religious beliefs with their professional lives, the external validity of the findings is limited. Nonetheless, this study serves as an important starting point for further cross-cultural research into this important area.

A second limitation of the study is the racial homogeneity of the sample: 95% of the participants were White, and 5% were Asian/Pacific Islander. No Black individuals were represented in the sample. Furthermore, of the 60 individuals who participated in the study, only one identified as Hispanic. An individual's ethnicity may be associated with variability in the degree of his or her religious fundamentalism, his or her attitudes toward gay and lesbian individuals, or the extent to which attitudes toward gay and lesbian individuals moderates the relationship between religious fundamentalism and gay affirmative practice, limiting the external validity of the findings of this study.

This study is also limited by the correlational nature of the data. We have interpreted the causal associations among the constructs measured based on a theoretical framework; however, it is important to note that the association among certain variables may be reversed or subject to a spurious effect. Thus, for example, it may be that religious fundamentalism leads to more negative attitudes toward lesbian and gay individuals; however, it is also hypothetically possible that having more negative attitudes toward lesbian and gay individuals might lead someone to identify with religious values that align with those attitudes. Alternatively, it is possible that a third variable that was not measured in this study, such as conservativeness or authoritarianism, might lead to both religious fundamentalism and to more negative attitudes toward lesbian and gay individuals and, thus, account for the association between the latter two constructs.

Furthermore, because of the cross-sectional design, the mediation model posited may also be interpreted in multiple ways. As in the example above, it is possible that having more negative attitudes toward gay and lesbian individuals might lead someone to identify with religious values that align with those attitudes, while simultaneously leading to less adherence to gay affirmative practice; it is also possible that conservativeness or some other personality factor might account for the associations among the three variables, without any causal relation among them.

In addition to the above considerations regarding interpretation of our findings, it is important to note that overlap among the constructs measured may generate a degree of tautology that could account for some of the association among variables. For example, if religious fundamentalism denotes belief in the absolute truth of one's religious doctrine, and if one's religious doctrine denounces LG orientations as sinful, then rather than saying that religious fundamentalism leads to more negative attitudes toward LG orientations, it may be more correct to say that these attitudes are part and parcel of that individual's religious fundamentalism. Similarly, gay affirmative practice involves endorsing LG orientations as desirable forms of sexuality, and this is reflected in some of the items that compose the GAP; thus, it may be more correct to say that attitudes toward LG orientations constitute part of one's adherence to gay affirmative practice than to say that these attitudes affect one's degree of adherence thereto.

Finally, although this is not a limitation per se, it is important to note that this study demonstrates an association among religious *fundamentalism*, attitudes toward LG orientations, and gay affirmative practice. Notably, religious fundamentalism is distinct from other dimensions of religiosity and spirituality, and our findings thus do not indicate anything about these other dimensions as they relate to this area of research. In fact, all participants in this study self-identified as religious, yet the mean level of agreement with items on the RFS was 3.05 ($SD = .64$), corresponding to "neither agree nor disagree," demonstrating the dissociation of these constructs. Additional research is necessary to investigate the role of other dimensions of religiosity in this area.

Despite the above limitations, this is the first empirical study to investigate how individuals faced with conflicts between two sets of values negotiate these situations. As such, it paves the way for future research on this topic, with re-

gard to ethical conflicts both in the clinical setting and in general. Future research should investigate additional methods of handling ethical conflicts and which factors (e.g., personality, training in professional ethics, social support) predict the methods an individual uses. Future research should also consider other dimensions of religiosity and their association with the constructs assessed in this study.

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