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Assessing Service Providers at LGBTQ-Affirming Community Agencies on Their Perceptions of Training Needs and Barriers to Service

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Service providers (N = 109) at lesbian, gay, bisexual, transgender, and questioning (LGBTQ)-affirming social service agencies were surveyed on their perceived training needs, experiences, and barriers to service access experienced by their clients. Hierarchical regression analysis identified that training experiences significantly influenced self-perceived competence, controlling for agency-related factors including the extent of perceived barriers to service. Findings are discussed with implications for training, practice, and future research.

KEYWORDS *LGBT centers, service providers, client barriers, regression*

INTRODUCTION

Scholarship indicates that self-identifying lesbian, gay, bisexual, transgender, and questioning (LGBTQ) people experience higher rates of stress and related negative health outcomes than do other populations (Haas et al., 2011). These include higher rates of mental and physical health concerns, experiences of violence, and other indices of stress as a function of their social marginalization and stigmatization, still prevalent in Western(ized) societies including the United States (Institute of Medicine [IOM], 2011; Mink, Lindley, & Weinstein, 2014). In response to these needs, and to resist the stigma and marginalization experienced in available social and health care services settings, organizations have developed across the United States that specialize in providing open and affirming services to LGBTQ individuals

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(Lee, 2013). These organizations include counseling and psychotherapy clinics, community centers, medical and case management services, and other types of services (e.g., elder support) that meet the local and specific needs of LGBTQ people (Wheldon & Kirby, 2013). While research has been conducted on the needs of various communities of LGBTQ persons, including LGBTQ youths of color (Wagaman, 2014), transgender and binary gender-nonconforming people (Redfern & Sinclair, 2014), lesbian survivors of intimate partner violence (IPV) (Simpson & Helfrich, 2014), and HIV-positive men that have sex with other men (MSM) (Wheldon & Kirby, 2013), little is known about the needs, perspectives, or experiences of service providers working at historically LGBTQ-affirming agencies (Alvy et al., 2011).

As LGBTQ people become more accepted across society, providers of social and health care services will be expected to demonstrate competency to engage members of these historically marginalized populations (Chonody, Woodford, Brennan, Newman, & Wang, 2014; Simpson & Helfrich, 2014; Whitman & Bidell, 2014). Staff and personnel at LGBTQ-affirming organizations have valuable direct experience providing services that LGBTQ individuals rely on to address basic needs, not the least of which is providing a sense of connection and community to people still at risk of being shunned by friends, family, and society (Wagaman, 2014). The purpose of this study is to explore the perspectives of LGBTQ service providers at organizations historically allied with LGBTQ individuals and communities. Specifically, the authors sought to examine how providers' sense of being adequately prepared for work with LGBTQ clients was influenced by past training experiences and awareness of barriers to their clients' service access. The following is a critical review of the literature that examines studies on service providers' competency and training in LGBTQ issues, literature on barriers to clients' service access, and the role that LGBTQ-affirming social service centers have played in the health and well-being of LGBTQ communities.

LITERATURE REVIEW

Social Services for LGBTQ People

The provision of affirming social support and care services to LGBTQ people has a multi-decade history in the United States (Lee, 2013). Prior to the increased advocacy for LGBTQ affirmation and liberation occurring in the 1970s and 1980s, LGBTQ individuals often relied on one another for their mental, emotional, social, and physical well-being (Lee, 2013). After the mass mobilizations of LGBTQ people and their allies occurring in response to the HIV/AIDS epidemic, social service and health care organizations are increasingly expected to serve the needs of LGBTQ individuals in a culturally competent and affirming manner (Alvy et al., 2011; Wheldon & Kirby, 2013). To date, various allied mental health and social service professions have

endorsed affirmation of gender and sexuality diversity as the standard of care when working with LGBTQ people and their families, allies, and communities; these professions include social workers (Fredriksen-Goldsen, Hoy-Ellis, Goldsen, Emler, & Hoyman, 2014), psychologists (American Psychological Association [APA], 2012), professional counselors and school counselors (Harper et al., 2013; Smith, 2013), and physicians (Rutherford, McIntyre, Daley, & Ross, 2012).

While professional standards for the provision of affirming and culturally competent services with and on behalf of LGBTQ individuals is a welcome structural change, there is evidence that service providers vary in their respective LGBTQ-related attitudes and competencies (Anderson & Holliday, 2008; Chonody et al., 2014). Understanding of standards developed for specific professions that might also inform the practices of paraprofessional and other allied service providers is currently lacking. One variable associated with improving providers' competencies for work with LGBTQ individuals is direct training on LGBTQ issues (Leyva, Breshears, & Ringstad, 2014; Rutter, Estrada, Ferguson, & Diggs, 2008). Studies on providers' LGBTQ cultural competency often recruit participants from service and health care organizations not historically associated with LGBTQ affirmation as an essential component of their mission (Erdley, Anklam, & Reardon, 2013; Jenkins Morales, King, Hiler, Coopwood, & Wayland, 2014). Given the importance of LGBTQ advocacy and social service organizations in the movement to create a more affirming society for LGBTQ people, it is important to conduct research directly on the experiences and perspectives of providers in these organizations as they can help shape what is an emerging social service and health care specialty.

Giwa and Greensmith (2012) conducted a phenomenology on LGBTQ service providers from non-dominant heritage backgrounds and their experiences related to race and racism, finding that the themes of White privilege, within-group micro-aggression, and internalized racial prejudice were trustworthy depictions of participants' experiences. Participants from this study also identified these themes as important for understanding the needs of their non-White clients as well (Giwa & Greensmith, 2012); while well-designed, confirmation of the study's findings across both similar and different samples of service providers is needed.

In another qualitative study based on narrative methods, Simpson and Helfrich (2014) synthesized the experiences of African-American, lesbian survivors of IPV in terms of the participants' perceptions of barriers to service access. Themes developed through constant-comparative analysis included the dynamics of intersecting social barriers (e.g., sexism, racism, heterosexism, able-body-ism, and classism) and agency-related institutional barriers (such as policies or lack of provider training on LGBTQ issues). Simpson and Helfrich (2014) did not specify if participants associated these barriers equally, or at all, to LGBTQ-affirming organizations. Wheldon and Kirby

(2013) investigated how access to services impacted the expression of known physical and mental health disparities in a sample of self-identifying gay, bisexual, and other men who have sex with other men (MSM), finding that sexual minority participants were not less likely to access care than heterosexually identifying counterparts but were less likely to report having access to health care insurance. One possible explanation suggested for the lack of disparity in health care access in this study is the presence of LGBTQ social service organizations (Wheldon & Kirby, 2013); the extent to which participants received services from LGBTQ-affirming organizations was not directly assessed.

Erdley and colleagues (2013) found that LGBTQ-affirming organizations, or known LGBTQ allies within larger organizations, were the preferred providers of choice for a sample of older LGBTQ participants in a cross-sectional, naturalistic study. Similarly, Davis, Saltzburg, and Locke (2010) found that LGBTQ youths identified a preference for known LGBTQ allies in terms of addressing school-based needs; these youths also identified a need for better training across professional types in terms of providing LGBTQ-affirming service. How aware these youths were of LGBTQ-affirming organizations available in their respective communities was not investigated. A qualitative-hermeneutic investigation of LGBTQ youths by Wagaman (2014) found that LGBTQ service centers were consistently perceived by participants as places where connections could be fostered, and needs for safety, support, and community could be met. Another reliable and stable theme identified by Wagaman (2014) involved how, though supportive, personnel at LGBTQ service centers could engage in stereotyped or biased thinking when interacting with participants.

The emerging scholarly interest in LGBTQ service providers as a professional group would benefit from awareness of how within-group differences for this population impact salient outcomes such as client barrier to service access. More scholarship that facilitates generalization of findings to diverse populations of LGBTQ service providers is also needed. Exploring the question of what constitutes effective and meaningful provision of services to LGBTQ people, grounded in the perspectives of providers already engaged in service work at LGBTQ-affirming agencies, can begin to fill the gap in knowledge and help provide practice-based evidence for further development of interdisciplinary standards.

Barriers to Service

Scholars have investigated what factors or dynamics operate as barriers to social and health care service access for LGBTQ populations. One consistent finding involves how experience of discrimination, or anxiety about the potential to be discriminated against, impedes LGBTQ individuals' ability and willingness to seek out basic health care and social services (Steinsvag,

Sandkjaer, & Storksen, 2004; Wheldon & Kirby, 2013). This discrimination manifests overtly and covertly, often due to providers' lack of awareness of personal attitudes rooted in tacit heterosexist (Chonody et al., 2014) and cis-gender prejudice (Taylor, 2013). Discrimination based on heterosexism and cisgender bias also intersects with other sources of prejudice including racism (Giwa & Greensmith, 2012), socioeconomic class bias (Jenkins Morales et al., 2014), ageism (Fredriksen-Goldsen et al., 2014), and lack of awareness of the needs of immigrants (Coleman, Irwin, Wilson, & Miller, 2014) to limit LGBTQ individuals' access to services and support (Simpson & Helfrich, 2014). Providers' ability to think and act from an intersectional perspective relative to reducing client barriers to service access is considered best practice and is facilitated by accurate assessment of client needs by competent service professionals (IOM, 2011; Mink et al., 2014). This includes conceptualizing needs from a systemic perspective, factoring in barriers or obstacles related to organizational policy, clients' material needs such as transportation costs, and the impact of experiences with other service providers or professionals who exhibit low to no LGBTQ cultural competency (Jenkins Morales et al., 2014; Mink et al., 2014).

While there is consistency in the literature about sources of barriers to client service access, little is known about providers' awareness of these barriers. It follows that LGBTQ clients want providers across service settings to be open and affirming (Coleman et al., 2014; Steinsvag et al., 2004), but few studies have directly assessed how able providers at LGBTQ-affirming organizations are to recognize the discreet and intersecting factors acting as barriers for their clients. Needs assessment data, such as that garnered by Jenkins Morales and colleagues (2014) or Coleman and colleagues (2014), is useful for identifying potential domains for further exploration though it is commonly analyzed descriptively from non-randomized samples. Exploring the views of providers who work at agencies already purposed to provide open, affirming, and competent service to LGBTQ populations can help texture the literature on barriers to access for these populations as understood by professionals with more direct involvement with LGBTQ individuals and communities. The relationship between providers' perspectives and how closely they resonate with clients' own views is an as yet underdeveloped area in the knowledge base. The training that providers receive to recognize identified barriers, and to work through them to provide competent service to LGBTQ clients, is also in need of further attention.

LGBTQ Competence and Training

According to Mayer and colleagues (2008), training is essential in health care service providers' work with LGBTQ populations across practice settings and disciplines. Standards created by professional associations for social and health care services fields for work with LGBTQ individuals are useful

for benchmarking competency and for identifying training objectives. One common theme across different sets of standards is that culturally competent work with LGBTQ people includes awareness of how stigma, minority stress, and prejudice impact the successful psychosocial development of members from these historically marginalized populations (APA, 2012; Fredriksen-Goldsen et al., 2014; Harper et al., 2013; Mink et al., 2014; Rutherford et al., 2012). Along with awareness of minority stress, practitioners are expected to engage in critical self-analysis of personal and professional attitudes toward sexual orientation, gender identity, and the intersection of these subjectivities with other identities over the life course (Fredriksen-Goldsen et al., 2014). Competent service providers must also understand how factors such as culture, religion, media, and health and human services systems influence the lives of LGBTQ individuals (Lee, 2013; Mink et al., 2014). Other sources of commonality across different competency standards include (a) identifying similarities, differences, and the influence of intersecting identities within subgroups of LGBTQ people (Moe, Perera-Diltz, Sepulveda, & Finnerty, 2014; Simpson & Helfrich, 2014); (b) applying established theories while keeping abreast of the most current knowledge available (Fredriksen-Goldsen et al., 2014); (c) using appropriate language in assessment and intervention (Troutman & Packer-Williams, 2014); and (d) awareness of how institutional policies and local, state, and federal laws impact the lives of LGBTQ people (Alvy et al., 2011).

Empirical studies have demonstrated the efficacy of using a knowledge, awareness, and skills competency-based framework to develop and implement training in LGBTQ issues for different types of service providers (Fredriksen-Goldsen et al., 2014; Leyva et al., 2014; Mayer et al., 2008; Rutter et al., 2008). In-person continuing education appears to impact providers' competency, and scholars have also found that relatively brief, Web-based trainings are also effective (Moone, Cagle, Croghan, & Smith, 2014). Leyva and colleagues (2014) found that service providers, as a result of cultural competency training, became more aware of their agency's general capabilities relative to LGBT populations, including how affirming or inclusive the agency was. These studies lend insight on the impact of cultural competency trainings on service providers and illumine areas for future research on the topic, especially as there is an indication service providers in general lack adequate knowledge and skills for competent practice with LGBTQ populations (Chonody et al., 2014).

While training appears to be effective for increasing competency, little is known about the effects of different training types, such as graduate coursework or receiving supervision from an experienced LGBTQ ally. As self-awareness is emphasized as vital for providing competent service to LGBTQ people, providers with more training and experience should feel more prepared to work with LGBTQ individuals and communities. Linking indicators of agency-level functioning, such as the number of different

populations served and perceptions on barriers to service access, with past training would also support calls to infuse a systemic-ecological focus into competent work with LGBTQ individuals.

The focus of this study is on the views of service providers working at organizations where direct provision of social service and allied health care to LGBTQ individuals is part of the stated mission for the organization. Specifically, the authors sought to address the related research questions of what barriers to their clients' service access were perceived by service providers, how these related to providers' training experiences, and how both influenced providers' own sense of being adequately prepared to serve their clients. This study addresses this by identifying the perceptions of personnel and addressing gaps in previous research efforts. The principal research hypothesis for the present study was that training experiences would predict participants' sense of being adequately prepared to serve LGBTQ populations, controlling statistically for barriers to access, total number of populations served, age, ethno-cultural heritage with identifying as a minority serving as the reference group, and gender coded as identifying as a cisgender female serving as the reference group. An *a priori* significance level of .01 was used to assess results of the hierarchical multiple regression used as the hypothesis test in this study.

METHODOLOGY

Participants

Participants were asked to complete a brief demographic checklist to facilitate description of the participant sample. They were asked to indicate their (a) age in years, (b) ethno-cultural heritage(s), (c) modes of gender identification, (d) sexual-relational orientation(s), and (e) their highest degree of completion. A total of 109 ($N = 109$) participants completed the electronic survey. The mean age in years for the participant sample was 39.11 ($SD = 12.22$). In terms of sexual and relational orientation, 10.1% ($N = 11$) identified as bisexual, 23% ($N = 25$) as gay, 20.2% ($N = 22$) as heterosexual, 16.5% ($N = 18$) as lesbian, 21% ($N = 23$) as queer, and 9.2% ($n = 10$) as sexually fluid or non-identifying.

A total of 51.4% ($N = 56$) of participants identified as cisgender female, 28.4% ($N = 31$) as cisgender male, 5.5% ($N = 6$) as transgender female, 3.7% ($N = 4$) as transgender male, and 11% ($N = 12$) as gender queer or non-binary identifying. The ethnic and cultural heritage of the sample is as follows: 69% ($N = 75$) identified as European or European-American, 8% ($N = 9$) as African or African-American, 4.6% ($N = 5$) as East Asian or East Asian-American, 11% ($N = 12$) as Latino or Latina, 4.6% ($N = 5$) as multiple heritage, 1.8% ($N = 2$) as South Asian or South Asian-American, and .9% ($N = 1$) as Tribal Native American. Participants were also asked about their

highest educational degree, with 5.5% ($N = 6$) indicating their highest degree is a high school diploma, 2.8% ($N = 3$) an associate's degree, 29.4% ($N = 32$) a bachelor's, 48.6% ($N = 53$) a master's, and 12.8% ($N = 14$) a doctorate.

Survey

POPULATIONS SERVED

A checklist was created to assess whether the social service organization that employed individual participants served any of 10 different gender and sexuality diverse populations using a dichotomous, yes-or-no response. Potential service populations included the following:

1. lesbian women;
2. gay men;
3. bisexual women;
4. bisexual men;
5. women who have sex with other women (WSW; but don't identify as LGB);
6. men who have sex with other men;
7. transgender women;
8. transgender men;
9. queer-identified men and women; and
10. men and women questioning their gender identity and/or sexual-relational orientation.

Internal consistency estimates were not computed for responses to the populations served items, as they represent externally objective criteria and not either correct answers, ratings, or multiple-choice answers. Frequencies and the mean (including standard deviation) number of populations served are reported in the Results section.

BARRIERS TO SERVICE

Participants were asked to assess the importance of 16 barriers to service access experienced by LGBTQ clients at agencies where participants were employed as service providers by rating barriers using a 4-anchor, Likert-type response system. The 16 barriers were identified from critical review of the literature on service access issues experienced by LGBTQ individuals, and including both LGBTQ-affirming agencies and other types of social and health care service organizations. These barriers included client experiences with discrimination due to sexual and relational orientation (IOM, 2011; Steinsvag et al., 2004), transgender identity (Fredriksen-Goldsen et al., 2014), ethnicity, cultural heritage, and immigration issues (Giwa & Greensmith, 2012), age-based discrimination (i.e., ageism; Erdley et al., 2013), and issues related to

socioeconomic status or resources, transportation, legal issues, and access to health insurance (Jenkins Morales et al., 2014). Given scholarship on health disparities experienced by LGBTQ individuals (IOM, 2011; Rutherford et al., 2012), participants were also asked to assess how issues related to physical and mental health impacted their clients' service access. Finally, the literature base is clear on the importance of affirming the intersections between LGBTQ modes of being and other salient identities and lived experiences (Giwa & Greensmith, 2012; IOM, 2011; Meyer, 2010), and therefore participants were asked to assess how sexism, able-body bias, language ability, religious and spiritual beliefs, and connection to family of origin impacted service access. Each barrier could be rated with a 4-point, Likert-type anchor with 1 representing no importance and 4 representing very important. Given the non-dichotomous rating scale, participants' ratings of barriers were evaluated for stability using the Cronbach α inter-item consistency coefficient. The Cronbach's α for participant responses to the barriers to service scale for the present study is $\alpha = .91$.

TRAINING EXPERIENCES

A checklist was created for participants to rate the frequency of their training experiences in LGBTQ issues, including the number of completed undergraduate courses, graduate courses, and continuing education workshops. The participants were also asked if they had ever received supervision or mentorship from a LGBTQ-affirming social services practitioner, and if so, how many over the course of their career to date. Participants could indicate the frequency by selecting from one of seven indicators of frequency ranging from 0 to 6 or more; ratings of 6 or more were coded as 6 for computation and analysis purposes. The Cronbach's α for participants' reporting of their own training experiences in the present study is .79.

TRAINING NEEDS

Participants were asked to rate how prepared they and their professional colleagues are to provide services for LGBTQ clients using a 4-anchor, Likert-type scale with 1 representing strongly disagree and 4 representing strongly agree. The six items for this scale, adapted from Jenkins Morales and colleagues (2014), assess the need for training in LGBTQ issues from the perspective of social service professionals as opposed to clients or consumers. Items were split between rating colleagues and self-ratings. The three items assessing participant perception of colleagues' training needs were "My colleagues are aware of the needs of the LGBTQ populations"; "My colleagues have received professional training to assist them in their work with LGBTQ clients"; and "My colleagues are adequately trained to provide services to LGBTQ clients." The three items assessing participant self-rating of training

needs were “I have received professional training to assist me in my work with LGBTQ clients”; “I feel adequately trained for my work with LGBTQ populations”; and “I would like more professional development opportunities geared toward work with LGBTQ populations.” Cronbach’s α was not computed for these six items together as they were not utilized as a single measure or scale. Means and standard deviations for responses to these items are reported in the Results section.

Procedure

This study was reviewed by the human subjects review committee of the authors’ home institution and deemed exempt from full review due to limited impact on participants and procedures used to protect human subjects. A list of potential participants was created from the publicly available, professional e-mails of individuals listed as employees or associates of community social service agencies where lesbian, gay, bisexual, transgender, and other gender and sexuality diverse people can receive services in a safe and affirming setting. These agencies were identified from social service directories in large metropolitan areas where LGBT individuals cluster in accessible and visible communities; these areas included New York City, Washington, DC, Atlanta, Chicago, Houston, Columbus (Ohio), San Francisco, Los Angeles, Minneapolis, Seattle, and Austin (Texas). A total of 2,768 e-mails were identified, and from this a random sample of 1,107 (40%) e-mails were pulled using the SPSS 21 program. E-mails from this random sample were used to recruit participants; a random selection procedure was used to augment the external validity of study results. An electronic survey designed specifically for this study consisting of the barriers and needs questionnaire and a demographic checklist, along with an informed consent statement and information on how to participate in an incentive raffle, were input into an Internet-based survey program.

Potential participants were e-mailed up to four times with an invitation to participate, information on the incentive raffle (one of three \$25.00 gift cards), and a link to the electronic informed consent statement and survey. Participants indicating consent were directed to the start of the survey. Of the 1,107 e-mails from the random sample, 970 were valid (i.e., did not generate notices that the e-mail was defunct or out of use); of these, 11% ($N = 109$) finished the survey. Each participant was given a participant number, and a random drawing for the incentive was held to identify raffle winners after data collection was completed. Winners were notified, and all participants were notified the raffle had occurred and offered an executive summary of the results. Data were stored electronically in password-protected file storage programs, and only the authors have access to this data. Strengths and limitations of this sampling and recruitment procedure are examined later in the Discussion section.

Power Analysis

An *a priori* power analysis was conducted using the G*Power (Faul, Erdfelder, Buchner, & Lang, 2009) program, made available for free to faculty members at the authors' home institution. The parameters input into the G*Power program were an alpha level of .01 to interpret results, a targeted power level of .8, 1 predictor of interest in the regression model, six other predictors controlled for statistically in earlier steps, and an estimate for a moderate effect size for the predictor of interest (training) on the criterion (self-perceived adequacy to provide services to LGBTQ clients). Using these parameters, a sample size of 94 was identified as necessary to achieve adequate statistical power using Cohen's (1988) criteria. Given that the sample consisted of 109 participants, and that a moderate effect size was observed between the predictor of interest and the criterion, the desired power level of .8 was achieved.

RESULTS

Descriptive Statistics

POPULATIONS SERVED

Frequencies for each client population were tabulated. The most common type of population served were gay men, with 89% ($N = 97$) of participants reporting that their organization provided open and affirming services to this client group. This was followed with 80% ($N = 87$) of participants indicating their agencies provided services to lesbian women. Participants could indicate service to more than one client population, so percentages are not cumulative. Bisexual women, bisexual men, and transgender women were client populations that 74% ($N = 76$) of participants identified as receiving services at the participants' agencies. Queer-identifying men and women were identified by 70% of participants ($N = 76$) as a population served. The same percentage for questioning men and women and for transgender men was reported by 66% ($N = 72$) participants. The smallest percentages were reported for non-identifying MSM and WSW, with 55% ($N = 60$) and 48% ($N = 52$) of participants indicating they provided services to these two client groups. The mean number of population types served was 7.1 ($SD = 3.0$), and the modal number of population types was 10, indicating that most often participants reported working at agencies where all populations listed on the questionnaire were served.

BARRIERS TO SERVICE

Means and standard deviations were computed for each barrier to service. Each barrier listed on the questionnaire was identified by at least one

participant as important, and the modal rating for each barrier to service access was a 3, or a rating of important. The mean participant rating for barriers resulting from discrimination due to client sexual orientation was 3.5 ($SD = .76$), due to client ethnicity or culture was 3.3 ($SD = .82$), to trans-prejudice 3.7 ($SD = .68$), to sexism 3.2 ($SD = .85$), to ability or able-ism 2.5 ($SD = 1.1$), to religion or spiritual beliefs 2.4 ($SD = 1.1$), and to ageism or aging 2.8 ($SD = 1.0$). The mean score for barriers resulting from issues related to mental health was 3.2 ($SD = .92$), to physical health 2.8 ($SD = .98$), to transportation 2.9 ($SD = 1.1$), to financial resources 3.4 ($SD = .79$), to legal concerns 2.8 ($SD = 1.0$), to having health insurance (or not) 3.1 ($SD = .97$), to issues related to immigration status 2.7 ($SD = 1.6$), and to language ability 2.5 ($SD = 1.1$). Finally, the average rating for barriers to service related to issues in the clients' families of origin (as perceived by the participants) was 3.0 ($SD = 1.1$). The mean overall score for the relative importance of barriers to service was 47.7 ($SD = 10.3$), with a range of 24 to 64.

TRAINING EXPERIENCES

Descriptive statistics were calculated for the number of training experiences in LGBTQ issues, including undergraduate courses, graduate courses, number of supervisors and of mentors who were LGBTQ allies, and the number of workshops attended. Participants reported having taken an average number of undergraduate courses in LGBTQ issues at $M = 1.9$ ($SD = 2.3$), and the average number of graduate courses at $M = 1.6$ ($SD = 2.1$). The average number of workshops attended in LGBTQ issues was reported by participants to be $M = 4.4$ ($SD = 2.2$). The average number of supervisor-allies was $M = 3.8$ ($SD = 2.0$), and the average number of mentor-allies was $M = 3.7$ ($SD = 2.1$). The average total number of training experiences was $M = 15.3$ ($SD = 7.9$), with a range of 0 to 30.

TRAINING NEEDS

Participants were asked about their colleagues' awareness of LGBTQ client issues and concerns, whether their colleagues' had received training to meet those concerns, and how adequately prepared their colleagues are to meet the needs of LGBTQ clients. Participants' mean rating for their colleagues' awareness was $M = 3.5$ ($SD = .73$), whether their colleagues had received training was $M = 3.0$ ($SD = .86$), and how prepared their colleagues are to work with LGBTQ clients was $M = 3.1$ ($SD = .87$). Participants were also asked to rate their own training and preparedness, and whether they would like more training opportunities. Participants' mean self-rating for receiving training was $M = 3.2$ ($SD = 1.0$), for feeling prepared to work with LGBTQ clients was $M = 3.3$ ($SD = .90$), and for desiring more training opportunities was $M = 3.3$ ($SD = .86$). Participants' self-rating of their own preparedness to work with LGBTQ clients served as the criterion (i.e., dependent)

TABLE 1 Inter-Correlations for Continuous Barriers and Training Variables ($N = 109$)

	1	2	3	4	5	6	7	8	9	10
1. Barriers	—	.20*	.11	.16	.21*	.15	.16	.20*	-.05	-.02
2. Populations		—	.01	.11	.14	.07	.17	.17	-.31**	.14
3. Undergrad			—	.48*	.42*	.42*	.31*	.72**	-.36**	.24*
4. Graduate				—	.41*	.23**	.34**	.67**	.09	.17
5. Supervisors					—	.74**	.56**	.83**	-.15	.30**
6. Mentors						—	.52**	.78**	-.09	.31**
7. Workshops							—	.73**	-.09	.42**
8. Training								—	-.18	.38**
9. Age									—	-.12
10. Prepared										—

Note. Barriers = sum of barriers to service; Populations = sum of population types served at participants' agencies; Undergrad = number of undergraduate courses taken in LGBTQ issues; Graduate = number of graduate courses taken in LGBTQ issues; Supervisors = the total number of supervisor-allies the participant has in his or her career to date; Mentors = the total number of mentor-allies the participant has had separate from his or her supervisors; Workshops = total number of workshops on LGBTQ issues to date; Training = sum of all training experiences, including undergraduate and graduate courses, workshops, supervisors, and mentors; Age = age in years; Prepared = how prepared participants feel to work with LGBTQ clients.

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

variable in the hierarchical multiple regression model, described later. The total training needs score was not computed as the items represent two different modes of response, one for participants' colleagues and one for themselves.

Correlations

A series of Pearson product-moment correlation coefficients were calculated between continuous variables (see Table 1) to assess their relationships, and significant correlations are reported here. Participant total scores for barriers to service were correlated to total training experiences and to total number of populations served. Both relationships were small and positive, indicating that participants rating more barriers to service were also likely to have more training experiences in LGBTQ issues and to work at agencies serving more LGBTQ population types (see Table 1). Barriers to service ratings were also correlated to the number of supervisor-allies participants reported disaggregated from other training experiences; the relationship was small and positive. Participant age was negatively correlated to the total populations served, indicating that participants reporting higher age in years rated their agencies as serving fewer LGBTQ population types. Age in years was also negatively correlated to the number of undergraduate courses completed in LGBTQ issues. Training experiences were correlated to participants' ratings of their own preparedness to work with LGBTQ clients, evidencing a moderate and positive relationship.

Calculated separately, participants also evidenced small and positive correlations between their feeling of preparedness and to the number of undergraduate courses completed in LGBTQ issues, the number of supervisors and mentors who were LGBTQ allies, and a moderate and positive correlation to the number of workshops completed in LGBTQ issues. Review of the correlations helped to assess what variables were appropriate to include in the hierarchical multiple regression analysis, with small or moderate correlations being desirable between the criterion and the predictor variables (Tabachnick & Fidell, 2013). See Table 1 for r values and significance levels for all correlations.

Regression

PRIMARY ANALYSIS

A hierarchical multiple regression analysis was computed to assess the effect of training experiences on providers' self-perceived training adequacy, controlling statistically for the effects of identifying as female, non-European cultural heritage, participant age, extent of perceived barriers to service access, and total LGBTQ population types served. Training experience was computed from the total number of undergraduate courses, graduate courses, affirming supervisors, affirming mentors, and workshops or continuing education sessions completed by each participant. Participant demographic variables (age, cultural heritage, and gender) were entered into Step 1 of the analysis. Step 2 was comprised of total barriers to client service access as perceived by participants, and the total number of different LGBTQ population types served by the participants' agencies. Finally, total training experiences was entered into Step 3 as the independent variable. All continuous variables were assessed for linearity, co-linearity, normalcy, and kurtosis; variables conformed to acceptable standards and so the assumptions for the hierarchical model were met. An *a priori* α level of .01 was used to interpret results, given the use of self-report data and the relatively small rate of participant return.

Training experiences did demonstrate a significant effect on participants' perceptions of their own adequacy for working with the LGBTQ populations served at their respective agencies, controlling for the effects of status variables (female gender, non-European cultural heritage, and age), and agency variables (total types of different LGBTQ populations served and barriers to clients' service access), $F(6, 101) = 3.51$, $p = .003$, 95% CI [.021, .063]. The beta weight for training was $t(3.95) = .042$, and the unique variance for the effect of training experiences on self-perceived adequacy was $R^2 = .128$, or 12.8% of shared variance. This indicates a moderate effect size for training experiences on self-perceived adequacy.

POST HOC ANALYSES

To assess the relative influence of each type of training experience upon participants' self-perceived adequacy, two more hierarchical multiple regression analyses were conducted. The first disaggregated the training experiences instead of using a single training score; the new variables entered into the regression equation were undergraduate courses, graduate courses, supervisors, mentors, and workshops entered individually into the final step over and above status variables at Step 1 and agency variables at Step 2. An α level of .01 was also used to evaluate the post hoc tests. As expected, the variables entered separately continued to demonstrate a significant effect upon self-perceived adequacy to provide services, $F(10, 95) = 2.74, p = .005$, but examination of the unstandardized beta weights revealed that only the number of completed workshops on LGBTQ issues (95% CI [.049, 2.36]) appeared to be contributing to the significant result. To be able to interpret the unique influence of completed workshops on self-perceived adequacy, a final post hoc regression was conducted with workshops entered as an independent variable in its own step. Workshops completed in LGBTQ issues demonstrated a significant effect on participants' self-perceived adequacy, $F(10, 95) = 2.73, p = .005, 95\% \text{ CI } [.049, .236]$, controlling for the influence of other training experiences, agency variables, and status variables. The R^2 change associated with the effect was .075, indicating that 7.5% of the variance in self-perceived adequacy was associated with the number of workshops completed. This indicates a small effect for the unique influence of workshops upon self-perceived adequacy. The implications for workshops being the only training variable demonstrating a significant and unique effect upon participants' perceived adequacy for providing services are discussed next.

DISCUSSION

The authors of the present study sought to add to the knowledge base by surveying providers at LGBTQ-affirming social service agencies relative to training and barriers to client service access. At the descriptive level, the findings coincide with similar research on barriers to access identified by needs assessment approaches focused on the perceived needs of LGBTQ clients (Coleman et al., 2014; Davis et al., 2010; Jenkins Morales et al., 2014). Participants appeared to be aware of barriers to service access that have also been identified as common for LGBTQ populations by other scholars, such as discrimination due to sexual-relational orientation (Fredriksen-Goldsen et al., 2014), gender identity (Redfern & Sinclair, 2014), sexism and able-ism (Simpson & Helfrich, 2014), and racism (Giwa & Greensmith, 2012). While average ratings for legal difficulties, immigration status, language differences, and religious-spiritual beliefs acting as barriers to access were lower, the

modal rating for each of these barriers indicate participants most commonly identified these as important barriers for at least some client populations (Coleman et al., 2014). One barrier not assessed directly in this study was awareness of clients' sense of isolation or loneliness, a factor identified by Erdley and colleagues (2013) as important for conceptualizing the needs of LGBTQ individuals. Experiences with family of origin was assessed, and similar to Erdley and colleagues (2013) and other scholars (e.g., Davis et al., 2010) this was on average identified as an important barrier to service.

The positive and significant correlations looking at the relationships among training experiences, perceived barriers to service access, and number of different LGBTQ populations served could be understood through several lenses; it is important to note that correlation does not equal causation. The relationship between perception of barriers and number of types of LGBTQ populations served could be a function of scale, where those working with a greater variety of populations are exposed to more barriers experienced by clients. Having more training in LGBTQ issues may result in better ability to identify barriers to access, and also make one more likely to work at organizations serving a more diverse clientele. Conversely, agencies providing services to multiple LGBTQ communities may encourage or require more training. In one study it was found that service providers were more aware of their agency's friendliness toward LGBTQ populations after receiving cultural competence training (Leyva et al., 2014). As is the case throughout the social service sector (Jenkins Morales et al., 2014), resources to meet clients' intersecting needs at LGBTQ centers or agencies may be scarce. Agencies where multiple types of LGBTQ populations are served may then be taxed to address different needs such as those related to ability status, monetary resources, health insurance, or discrimination, and so providers at these agencies may be more likely to identify these barriers as important. More research on the relationship between LGBTQ agency size and resources, and the experience of service access for LGBTQ clients, is needed.

Participants reported completing a range of training experiences in LGBTQ issues, including undergraduate and graduate coursework, receiving supervision from a LGBTQ ally, interacting with non-supervisor mentors (also allies), and continuing education and workshops, with a majority of respondents reporting at least one of each type of experience. Use of hierarchical multiple regression analyses revealed that training experiences did significantly predict participants' perceived adequacy to meet the needs of LGBTQ clients, controlling statistically for demographic variables, ratings of barriers to service access, and the number of different populations served. Post hoc analysis identified that the only number of workshops completed as continuing education in LGBTQ issues provided unique variance to participants' self-perceived adequacy, controlling statistically for the other types

of training experiences. Leyva and colleagues (2014) found that sessions in LGBTQ cultural competency significantly increased interdisciplinary service providers' knowledge, attitudes, and skills relative to work with LGBTQ clients. Workshops have also been found to be associated with counselors' sexual orientation competency in correlation-based studies more generally (Bidell, 2014). Recalling that correlation does not equal causation, the finding from the present study could mean that participants reporting completion of more workshops are more likely to report feeling adequately prepared because of the effect of the workshops or that those feeling prepared are more likely to seek out continuing education. Continued training in LGBTQ issues, including being able to view LGBTQ individuals as occupying multiple dynamic identities with intersecting needs, is affirmed by scholars as vital for both novice and experienced providers (Erdley et al., 2013; Leyva et al., 2014; Moe, Perera-Diltz, & Sepulveda, 2014).

As providers at health care and social service agencies across the United States seek to develop competence with LGBTQ populations, the findings from the present study support the potential utility of workshops and continuing education in fostering this important competency need. Research on what content is most salient to include in such training sessions needs refinement, as different professional groups set standards for their own members. Frequency of training is also important in addressing participants' feeling of preparedness. Agencies may consider annual trainings and also a series of trainings that run throughout the year. These trainings can focus on specific subpopulations being serviced by the agency using the knowledge-attitudes-skills competency framework. Topics should rotate and introduce new skills to be up-to-date with industry trends, possibly addressing standards set by organizations that govern the different professions or filling in gaps where standards are lacking (Troutman & Packer-Williams, 2014; Leyva et al., 2014).

Areas of overlap and consensus in meeting the needs of LGBTQ individuals have been identified (IOM, 2011), and efforts to further synthesize standards for training and competency emergent across disciplines are warranted. Mink and colleagues (2014) propose an asset-based, intersectional-ecology model of LGBTQ health, where LGBTQ individuals' development is viewed as dynamic, occurring over the life span, grounded in sources of resiliency and wellness, and embedded within multiple overlapping social contexts including heterosexism. Theoretical developments such as that proposed by Mink and colleagues (2014) may serve as a valuable integration of emerging perspectives, serving to guide training and practice across disciplines. Further empirical validation of such theoretical models is needed. The experience of service providers already engaged in LGBTQ advocacy and care is an important resource and further efforts to integrate these providers' perspective into the development of interprofessional standards would help enrich social service practice with and on behalf of LGBTQ clients.

Limitations

The study design is subject to several limitations that are important for readers to consider. Findings from cross-sectional, Web-based, and naturalistic surveys may be subject to the special characteristics of respondents and therefore not generalizable to larger populations. A larger sample may have decreased measurement error and altered the apparent relationships between variables in the present study. As an anonymous Web-based survey, characteristics of non-responders were not analyzable. No traits or conditions were manipulated experimentally, and so causation should not be inferred from study findings. The use of externally valid criterion-keyed items and measures designed specifically for this study, while common in sociological and social service research, may have increased self-report bias effects. While there is no indication that participants were incentivized to misrepresent responses to the questionnaire, no assessment of their socially desirable responding or propensity for other types of response bias was conducted. The use of a randomized sample of participants increases both the internal and external validity of the findings, but also facilitated exclusion of potential participants and therefore artificially truncated the study sample. Replication with a larger sample is needed as well as use of longitudinal designs to facilitate evaluation of the stability of the findings across time.

Future Directions

Research on training and provider competency often overlooks the influence of provider behavior on clients, especially the link between specific behaviors and overall service efficacy. The researchers did not assess provider efficacy or effectiveness as measured by client welfare, and this would be an important future project to help link competency, provider behavior, and client outcomes more directly. Experimental designs comparing different types of workshop content and curricula to one another would help advance knowledge on effective training methods for promoting LGBTQ cultural competence. Designs that facilitate in-depth engagement with the lived experiences of clients, and of service providers, such as grounded theory approaches, could also enrich scholarly and theoretical work with concrete, embedded, and contextual awareness of the evolving needs of LGBTQ and allied individuals.

CONCLUSION

In creating a system that responds holistically to LGBTQ populations it is important to ensure that provider-allies feel prepared and competent in their duties. Advancement of social acceptance and civil rights for LGBTQ

people fosters a growing need for health care and social service providers across settings and disciplines to develop competency in meeting the needs of these historically marginalized groups. Advocates at historically LGBTQ-affirming agencies, as well as providers throughout the social service system, would benefit from continued training in LGBTQ issues as these issues change over time (Fredriksen-Goldsen et al., 2014; Leyva et al., 2014). Specialists in LGBTQ issues, fostered by practical experience, training, and engagement in communities of like-minded professionals, may be best-suited to provide leadership in terms of advancing LGBTQ competency across professions and settings. More work is needed to identify interdisciplinary standards, such as theoretical models for guiding practice, which providers across social service settings can apply in their work with LGBTQ clients.

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