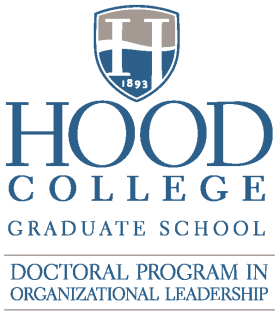

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Program: Doctoral Program in Organizational Leadership

Dissertation Title: The Role of Organizational Socialization on Job Satisfaction and Commitment for Fee-for-Service Mental Health Clinicians.

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I certify that I am the author of the work contained in this dissertation and that it represents my original research and conclusions. I pledge that apart from my committee, faculty, and other authorized support personnel and resources, I have received no assistance in developing the research, analysis, conclusions, or text contained in this document, nor has anyone written or provided any element of this work to me.

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HOOD COLLEGE

The Role of Organizational Socialization on Job Satisfaction and Commitment for Fee-for-Service Mental Health Clinicians

A DISSERTATION

Submitted to the Faculty of the

Graduate School of Hood College

In partial fulfilment of the requirements

for the degree

Doctor of Organizational Leadership

by

Vera Kurdian

Frederick, Maryland

2021

DOCTORAL COMMITTEE

The members of the committee appointed to examine the dissertation of Vera Kurdian find that this dissertation fulfills the requirements and meets the standards of the Hood College Doctoral Program in Organizational Leadership and recommend that it be approved.

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DEDICATION

This dissertation is dedicated to my staff, colleagues, and all social workers and counselors who worked tirelessly during the two pandemics. You put your needs aside and showed up every day to be there for your client and helped them get through these unprecedent times. You inspire me every day!

ACKNOWLEDGMENT

To my husband, Armen, whose love and support have no bounds and who has pushed me to succeed in more ways than one. To my children, Harout and Taleen, you are my inspiration. I am so proud to be your mother. My love for you is infinite! To my sister, Maral, who helped me find my voice, I hope to make you proud. To my cohort members, with whom I have developed lifelong friendships. To my committee members and, specifically, my Chair, Dr. Kathleen Bands, who believed in my abilities and supported me from day one.

The Role Organizational Socialization on Job Satisfaction and Commitment of Fee-for-Service Mental Health Clinicians

Vera Kurdian, DOL

Committee Chair: Dr. Kathleen Bands, Ph.D.

ABSTRACT

Increases in Americans' mental health needs, coupled with growing shortages of trained mental health clinicians, concern public and private mental health organizations. Increasing job satisfaction and staff commitment is crucial to reducing turnover as agencies compete to hire and retain staff. Currently, there is limited research about organizational socialization practices, job satisfaction, and affective commitment for fee-for-service clinicians working within outpatient mental health clinics. Fee-for-service organizations that want to attract new staff and sustain their existing workforce must examine their organizational socialization practices. With fee-for-service practice, clinicians are compensated based on their billable hours. In the absence of salaries, staff are hired and immediately given caseloads to generate revenue. Often overlooked is the failure to provide resources and skills to mitigate no shows, cancellations, and time management challenges. This research explored the role of organizational socialization on job satisfaction and affective commitment of fee-for-services clinicians. It also identified job satisfaction factors that lead to commitment. Eighty-one fee-for service clinicians completed an online survey of standardized questions to capture data on organizational socialization, job satisfaction, and affective commitment. Data were analyzed using path analysis to examine relationships. The findings revealed a statistically significant correlation between organizational socialization, job satisfaction, and affective commitment. Moreover, job satisfaction had a statistically significant influence on affective commitment.

CHAPTER 1 INTRODUCTION

The mental health workforce is on the verge of a crisis. By 2025, there will be a shortage of mental health providers, including social workers, psychiatrists, and marriage and family therapists (Health Resources Services Administration, 2016). According to the National Alliance on Mental Health (NAMI) (2019), 1 out of 5 individuals live with a mental health condition, and 1 out of 25 are diagnosed with a serious mental illness. NAMI estimated 47.6 million adults had experienced mental illness and approximately 11.1 million youth between 6 and 17 years of age were diagnosed with mental health disorders. Increased mental health awareness, reduced stigma, health care reform, federal legislative support to promote mental health intervention (Beck et al., 2018), COVID-19, and increased violence and racial injustice have increased the need for mental health care. Both historically significant and current events have highlighted the upcoming predicted shortage.

The increased demand for and shortage of mental health providers have resulted in delayed treatment and poor patient care (Levine, 2018; Thomas et al., 2009). Several agencies have reported on the scarcity of mental health clinicians. For example, the National Association of Social Workers (NASW) (2011) reported the lack of social workers in managed care (i.e., investing in social work workforce). More recently, the National Council for Mental Wellbeing (2017) reported a shortage of psychiatrists within the field of psychiatry. Additionally, in 2019, Senate Bill 944 passed in Maryland, and became codified (Md. Code Ann., Health-Gen. § 7.5-402). The new law changed the staffing criteria for outpatient mental health centers and allowed psychiatric nurse practitioners to act as medical directors. Although this change promoted the establishment of new clinics to meet the demands of the mentally ill, it did not address the already existing shortage of clinicians. Instead, it highlighted the lack of trained clinicians within

the field and contributed to the delay in services. After all, the underlying issue is not the absence of clinics but rather the lack of professionals who can offer much-needed services.

The year 2020 was a difficult year. Americans endured two major life-altering events. The first was the health pandemic of COVID-19 that wreaked havoc on the healthcare system and disrupted personal and family lives. As a result, government leaders were forced to take action to prevent the spread of the virus. An unprecedented "State of Emergency" closed most businesses leading to significant financial repercussions. Many families lost jobs and wages, and some families were unable to pay their bills. All indoor and outdoor activities were prohibited. Schools were closed, and only essential businesses were allowed to remain open with strict guidelines in efforts to stop the spread of the virus. The "stay home" orders increased isolation and anxiety, and intensified depression and other mental health issues expanding the need for treatment. Essential personnel were also overwhelmed due to many issues including lack of daycare for their children, lack of medical supplies, and longer work hours, increased workload (Sovold et al., 2021) that increased fatigue and the potential for burnout (Sultana et al., 2020).

While the world was dealing with the unpredictability of the virus, increased death toll, long-lasting health issues, and lost income, Americans dealt with a heightened sense of injustice towards the Black community that was identified as the second pandemic of 2020 (Addo, 2020). The events of the increased violence also led to senseless deaths and negatively impacted people's mental health and overall wellbeing. The lack of tolerance and hatred further escalated depression, anxiety, and trauma (Lewsley, 2020), increasing the need for mental health treatment and adding extra strain on mental health providers regardless of their place of employment (Evanoff et al., 2020).

Historically, the mental health field is low paying (Schweitzer et al., 2013), plagued with burnout (Lizano, 2015; Morse et al., 2012), high stress (Lloyd et al., 2009), compassion fatigue (Craig & Sprang, 2009; Geoffrion et al., 2016), and lack of autonomy (Morse et al., 2012). As early as 1979, the issues of poor salaries and high caseloads were few of the reasons leading to low job satisfaction and retention (Loewenberg, 1979).

To address both the shortage and turnover, leaders within the field can benefit from collaborating with their human resources departments to address three equally important priorities. First, acquiring the right talent can be a crucial step for retention. Coker (2019), for example, reported that talent management is not just a term but "the commitment an organization has in hiring, managing, developing, and retaining extremely talented individuals" (para. 1). Second, examining their organizational socialization activities and implementing effective practices to help new staff succeed can increase job satisfaction and commitment. Organizational socialization practices are activities that allow a newcomer an opportunity to learn about their organization, their specific role, and the needed skills to successfully integrate within the larger organization. Finally, recognizing the need to continuously engage and motivate staff to keep their level of job satisfaction high can also subsequently improve commitment.

Due to the projected shortages and the increased need for mental health clinicians, administrators cannot afford to ignore the relationship between what they offer new staff by way of their socialization practices and their level of commitment that influences a decision to stay. There is a large body of literature supporting the relationship between organizational socialization, job satisfaction, and commitment (Bauer et al., 2007; Saks et al., 2007; Bauer & Erdogan, 2011; Van Maanen & Schein, 1977; Abramson, 1993 & Abu-Doleh et al., 2018). Poor satisfaction breeds lack of commitment and ultimately can result in staff leaving to seek better

opportunities. Existing staff who are not fulfilled or continuously motivated and often challenged part from their positions to find better opportunities, contributing to turnover. High turnover is not only costly to organizations but has a lasting impact on employee morale and organizational performance (Aarons & Sawitzky, 2006; Markovich, 2019; Mull, 2016; Selden & Sawa, 2015).

There are many reasons for high turnover across different industries. Studies of private, public, and nonprofit industries have shown turnover due to organizational, economic, and individual conditions (Selden & Sawa, 2015). An example of an organizational condition that contributes to voluntary turnover is inefficient organizational socialization practices (e.g., onboarding) of new employees (Abu-Doleh & Obediat, 2018; Allen, 2006; Allen & Shanock, 2013; Carucci, 2018). Other organizational factors that influence turnover include better pay and benefits, flexible working conditions, and family friendly policies (Selden & Sowa, 2015; Selden et al., 2013). Poor job satisfaction and lack of commitment also contribute to employee turnover (Bauer & Erdogan, 2012; Brown et al., 2019).

To understand the staffing needs and clinician shortage, administrators need to be aware of historical changes that have contributed to the increased need for mental health treatment and to its influence on the scarcity of clinicians. These changes include increased awareness of the importance of mental health on the overall well-being of individuals, the de-stigmatization of mental health, societal and political events, as well as enacted laws that allowed broader coverage for mental health treatments.

Throughout history, individuals with mental health issues were treated poorly. As early as the Middle Ages, people believed that mental illness was a form of punishment from God (Rossler, 2016). Numerous establishments for inpatient psychiatric hospital care were developed throughout the 18th century. At that time, hospitalization was considered the most effective

method of treatment. By 1950, there was a push for outpatient community care in lieu of hospitalization. In 1963, President John F. Kennedy signed the Community Mental Health Centers Act of 1963, also known as the Mental Retardation and Community Mental Health Centers Construction Act of 1963. The act provided federal funding for community mental health centers (National Institutes of Health, 2017), resulting in many hospital closures. In addition to this act, strict standards were passed to hospitalize only those individuals who posed an imminent risk to self or others. This act promoted the birth of community clinics and increased awareness of the importance of mental health. It further granted community access to individuals seeking services (The National Council for Mental Wellbeing, n.d). Other major laws that significantly played a role to reducing stigma and increasing awareness were the Mental Health Parity and Addiction Equity Act MHPAEA of 2008 as well as the Affordable Care Act (ACA) in 2010 (National Institute of Health, 2017). The MHPAEA act required insurance companies to offer the same comprehensive benefits for mental health and medical issues equally, whereas the ACA offered affordable benefits and expanded the Medicaid program. These laws debunked the historical stigmatization associated with a mental health diagnosis, equalized insurance coverage, and normalized treatment.

While many laws were being enacted, a study that continues to impact mental health is the work of Felitti et al. (2019). This study heightened awareness about the importance of early intervention to promote general health. The Adverse Childhood Experiences (ACE) study examined the role of negative childhood experiences on the overall wellbeing of an adult person's life. The authors developed a questionnaire inquiring adults' negative experiences such as abuse, neglect, domestic violence, and sexual abuse during childhood and found positive relationship with adult obesity, poor physical and mental health, disease, and early death (Chang

et al., 2019; Felitti et al., 2019). Horn et al. (2019) also found that negative experiences increased the risk for developing mental disorders in children and adolescents. The study promoted the recognition and the importance of early intervention, assessment, and treatment and prompted professionals working with children and adolescents to make mental health referrals early on, further increasing the demand for services.

Finally, school violence, suicide, and the increase in school shootings led to enactments of many state laws to highlight the mental health needs of school aged children. Maryland has experienced its share of increased mental health demands in schools due to suicide, shootings, and other displays of violence. In 2015, Lauryn's law passed after a teenager in Prince George's County committed suicide. As a result, the law required school counselors to receive mandated training about prevention and intervention to assist in recognizing potential mental health indicators and providing necessary referrals. The Maryland Safe to Learn Act of 2018 is another law that passed after a school-related shooting in Saint Mary's County, Maryland. At a minimum, this new law mandated school personnel to address students' mental health needs and make proper referral recommendations.

The historical changes in increasing mental health awareness combined with heightened school violence, the pandemics, and increased political unrest accentuated the current and upcoming predicted shortage of mental health providers. These events have further increased challenges of attracting talent and retaining clinicians. In a field where turnover is high and job satisfaction and salaries are low (Calitz et al., 2014), mental health organizations can benefit from being creative in attracting new staff and continually engaging existing clinicians. With the abundance of opportunities in the marketplace, new clinicians may have difficulty finding the right fit with an agency that will pay living wages and offer opportunities for professional

growth. Further, in this position-rich environment, staff who are unsatisfied with their employment will seek better opportunities and voluntarily separate from their organizations to pursue other employments.

One way to increase job satisfaction and commitment is to offer staff effective organizational socialization (i.e., onboarding) experiences. A North American non-industry-specific employee engagement survey illustrated this point; it revealed that 64% of employees may leave their jobs due to lack of ongoing engagement (Durinski, 2020). In a field wrought with high stress, turnover, low wages, and poor job satisfaction (Calitz et al., 2014), leaders can benefit from exploring and implementing opportunities that can potentially resolve these long-standing retention problems or risk losing their staff. Currently, there is limited knowledge regarding the retention rate within the fee-for-service (FFS) mental health industry and this study will help better understand the role of organizational socialization on job satisfaction and commitment. A recent survey exploring retention revealed 42 million U.S. workers "decided there was something better elsewhere" (Mahan et al., 2020, p.7). FFS organization leaders cannot ignore these findings if they want their organizations to be competitive. Therefore, offering ongoing support, decent wages, and opportunities for growth and autonomy may potentially resolve the lack of retention.

Offering fair wages is important for retaining staff. In 2019, the U.S. Bureau of Labor and Statistics listed the average median salary for a full-time master-level licensed marriage and family therapist as $49,610 and $50,470 for master-level licensed social workers. A bachelor-level social worker cannot provide therapy, as most states, including Maryland, require a master's degree (U.S. Bureau of Labor Statistics, 2019). Compared to other fields with lower education requirements, mental health clinician salaries are comparatively low. For example, in

Maryland, a bachelor-level teacher's median salary is $61,660 (U.S. Bureau of Labor Statistics, 2019) and a master-level teacher makes on average of $77,187 (Maryland State Department of Education, 2018). Additionally, the annual median salary for a registered nurse ranges between $63,170 to $75,310 depending on the employment setting (U.S. Bureau of Labor Statistics, 2019.). These numbers show the disparity between the average salaries of mental health providers compared to fields that require less education and certification.

Autonomy in the field of mental health is another factor that impacts retention. Mental health clinicians can work in a variety of settings including public agencies, community clinics, public schools, and private practices. Staff who work for public agencies, such as child welfare or school systems, often receive compensation through government funding or grants. In these traditional settings, salaried employees work a minimum of 35-40 hour a week and are eligible to receive benefits such as health insurance, paid time off, promotional opportunities, retirement plans, and possibly continuing education to promote professional development.

Mental health clinicians who want to explore entrepreneurship establish private practices or join group practices. In private practice, clinicians secure offices on their own and establish a business plan to market their services. A group practice is a joint practice by multiple clinicians who create a unique business plan and share costs associated with their practice. Whether private or group practice, these mental health clinicians are entrepreneurs seeking self-employment. As such, they develop their own business policies and practices, charge higher fees, and have more flexibility in the hours they work. These clinicians are responsible for purchasing their own health and business insurance, liability coverage, savings for retirement, paying employment taxes, and other costs associated with running a business. These costs also include lost revenue due to no shows and cancellations.

An outpatient mental health centers (OMHC), sometimes referred to as a community clinic, is another setting mental health providers can choose as a place of employment. In this setting, clinicians provide treatment in schools, homes, and other community-based locations. Community-based intervention is not a new concept. Historically, schools or government-run agencies have determined the need for community or in-home services (Allen & Tracey, 2009; Boyd-Franklin & Bry, 2000). Community employees from these agencies have included parole officers and child protective service workers who aim to prevent abuse and offer rehabilitation and reunification services. As a result of this evolution and the enactment of laws to promote treatment, licensed clinicians are also allowed to offer treatment across a variety of settings beyond the traditional office setting (Beder, 1998). The flexibility of this model removes treatment barriers such as lack of transportation (Heath, 2017; Syed et al., 2013) and missed appointments (Miller & Ambrose, 2019*)*. The model further facilitates compliance with treatment and increases attendance (Slesnick & Prestopnick, 2004). This flexibility in offering treatment across a variety of settings have made OMHCs a popular place for clinicians to seek employment.

Some OMHCs have adopted a new productivity standard within nonprofit clinics (Hatchet & Coasten, 2018). These clinics hire mental health clinicians as independent contractors and compensate them based on their billable hours (Beidas et al., 2016). This type of compensation within the mental health field is referred to as fee-for-service (FFS). These clinics pay staff a percentage of their billable hours instead of set salaries. With this model, clinicians share the costs of no shows and cancellations as their clinics do not receive reimbursement for lost sessions (Hatchett & Coasten, 2018). Additionally, these contractual clinicians do not receive employment benefits beyond their salary. These organizations often do not allocate funds

to promote professional development for advancement (Beidas et al., 2016) which limits opportunities for increased professional knowledge and skill development.

For clinicians, the choice of employment in this environment presents a trade-off. Their personal situation and/or household income may be a determining factor for the type of work they choose. Some choose to work long hours for public or government agencies in exchange for stable salaries and fringe benefits. Others choose to work as contractual clinicians or in private practice for greater autonomy in lieu of benefits or a set income. As a result of these different models emerging in the last decade, a new type of OMHC has emerged.

These new OMHCs follow the model of FFS but hire and onboard staff differently. They do not treat their staff as contractual workers but as full-time employees. These OMHCs onboard clinicians and offer benefits and pay their payroll taxes. They offer opportunities that combine the benefits of salaried positions and the independence of private practitioners. These clinics promise high salaries because they pay the practitioner a percentage of their billable hours rather than a predetermined salary. The approach is based on the concept that incentive-based compensation models increase employee productivity, and more rigorous work results in greater rewards (Hamel, 2013). In this arrangement, clinicians are expected to provide 25-30 weekly sessions (personal anonymous communication, 2019), ranging from 20-60 minutes, depending on the type of approved reimbursable service provided. Based on Maryland Medicaid reimbursement rates for an average of 25 weekly sessions, the average salary for masters-level clinicians (e.g., LMSW, LGPC, and LMFT) can range between $75,000 to $81,000, while salaries for clinicians who hold advanced licensure billing 25-30 sessions a week can range between $82,000 to $90,000. These numbers are based on 45% to 55% of the reimbursement rates OMHCs offer across different counties in Maryland (personal anonymous communication,

2018). In addition to the high compensation percentage and flexibility of hours, these clinics offer paid supervision, continued training, and educational opportunities (websites of various OMHCs). Further, these clinics allow clinicians to provide therapy outside of the traditional in-office setting. Clinicians can exercise autonomy in managing their schedules, pay, and work hours. This is a selling point to clinicians who dislike sitting in an office with traditional "9 to 5" positions and seek compensation for their individual productivity rather than a preset salary.

Although the FFS model of compensation appears to offer a long-awaited solution to the challenges facing the mental health field (Calitz et al., 2014), it is not without its shortcomings. Despite efforts to find literature regarding working conditions of OMHC, limited information was found. As a result, I reviewed comments posted by employees of different OMHCs such as Google, Indeed, and Glassdoor reviews. The positive reviews highlighted the flexibility, the potential to earn high salary, and the autonomy of the position. The negative comments pointed out the lack of support and training, poor supervision, and the "sink or swim" attitude.

These drawbacks have made it more difficult for FFS outpatient clinics to retain staff. In the current labor market, there is competition for mental health providers. Often OMHC staff are hired with the promise of high salaries, given a short orientation about policies and billing rules, and then provided a case load and expected to succeed (personal communication anonymous, 2019). In the absence of a salary, there is less emphasis on engaging staff in nonbillable organizational socialization activities and an expectation to generate revenue. Within different commission-based sales industries, leaders have been cautioned to expect their new staff to increase sales without being provided proper strategies (Thomas, n. d). Weiss (2019) suggested that skill building, providing support, and promoting autonomy can potentially be favorable.

Similarly, these strategies can benefit FFS leaders who can implement similar strategies and eliminate challenges that can lead to turnover.

The FFS compensation model is not a new concept. Indeed, private and group practices existed at a time when psychiatric hospitals closed, and community therapy was supported. With laws promoting outpatient therapy, there has been a rise in the establishment of OMHCs. Limited research has identified factors contributing to job satisfaction for clinicians working in FFS clinics. Organizations plagued with high turnover and poor retention can benefit from understanding the needs of their new and tenured staff and mitigate turnover by turning to existing research on employee behaviors and how to approach both initial and ongoing socialization. These initial and ongoing activities can reduce anxiety and uncertainty associated with new positions, norms, and roles. Staff may also perpetuate feelings of connectedness, commitment, and job satisfaction (Allen, 2006; Bauer & Erdogan, 2011; Haueter et al., 2003). As an extension of this purposeful management, FFS organizations can also determine the needs of their existing staff and measure their job satisfaction to strengthen commitment.

Statement of the Problem

The turnover rate in the mental health field is high (Hoge et al., 2013; Howard & Gould, 2000; Lewis-Stoner, 2019; Miller, 2018), with annual rates exceeding 25% (Gallon et al., 2003) to 37% (Lewis-Stoner, 2019). Many scholarly articles have focused on organizational socialization, job satisfaction, and commitment of teachers, nurses, social workers, and other professional fields that discuss the relationship between organizational socialization, satisfaction, and commitment (Bratt & Felzer, 2012; De Gieter et al., 2011; Ellis et al., 2015; Fleury et al., 2018; Tomietto et al., 2015). There is limited research on organizational socialization, common factors associated with job satisfaction, and commitment of mental health clinicians specifically

working in FFS organizations. FFS positions require clinicians to have both clinical and basic understanding of business practices and how they impact compensation. Staff are attracted to these positions as they have the potential to earn higher wages than salaries in other mental health fields, establish a flexible schedule, and exercise autonomy to work as many hours as they choose. FFS clinicians can benefit from having both clinical training and business acumen. Ineffective organizational socialization practices to gain understanding of the business side of the clinical work leave clinicians unprepared to manage their time and address cancellations and no shows. These problems can tax clinicians leading to increased frustration and reduced income. Over time, these challenges can dimmish commitment and ultimately lead to voluntary separation.

To address these challenges, FFS clinics can benefit from examining their organizational socialization practices and identifying common factors contributing to job satisfaction to increase commitment. These steps will afford FFS clinics the opportunity to increase retention, particularly in light of personnel shortages and increased patient needs. The goal of this study is for leaders and administrators of OMHCs to improve their organizational practices to increase staff job satisfaction and their affective commitment and desire to stay. Additionally, it will provide literature about the experiences of FFS clinicians and their perceptions about the role of organizational socialization and its impact on their level of job satisfaction and desire to stay within their organization.

This study will benefit mental health organizations that compensate staff on their billable hours. Due to the mental health provider shortage, leaders in the FFS mental health industry can benefit from attending to the psychological well-being of their staff if they want to increase their performance and affective commitment (Kundi et al., 2020). This includes providing effective

socialization practices, listening to staff's needs, understanding what motivates them, and developing programs to further their growth. These efforts can impact staff's job satisfaction and affective commitment. Additionally, this study will fill the gap in literature by providing new information for future research about this new model of compensation within the mental health industry. Finally, the study may also inform higher education institutions to include business-related content to their curriculum to help future graduates succeed in FFS organizations.

Conceptual Framework

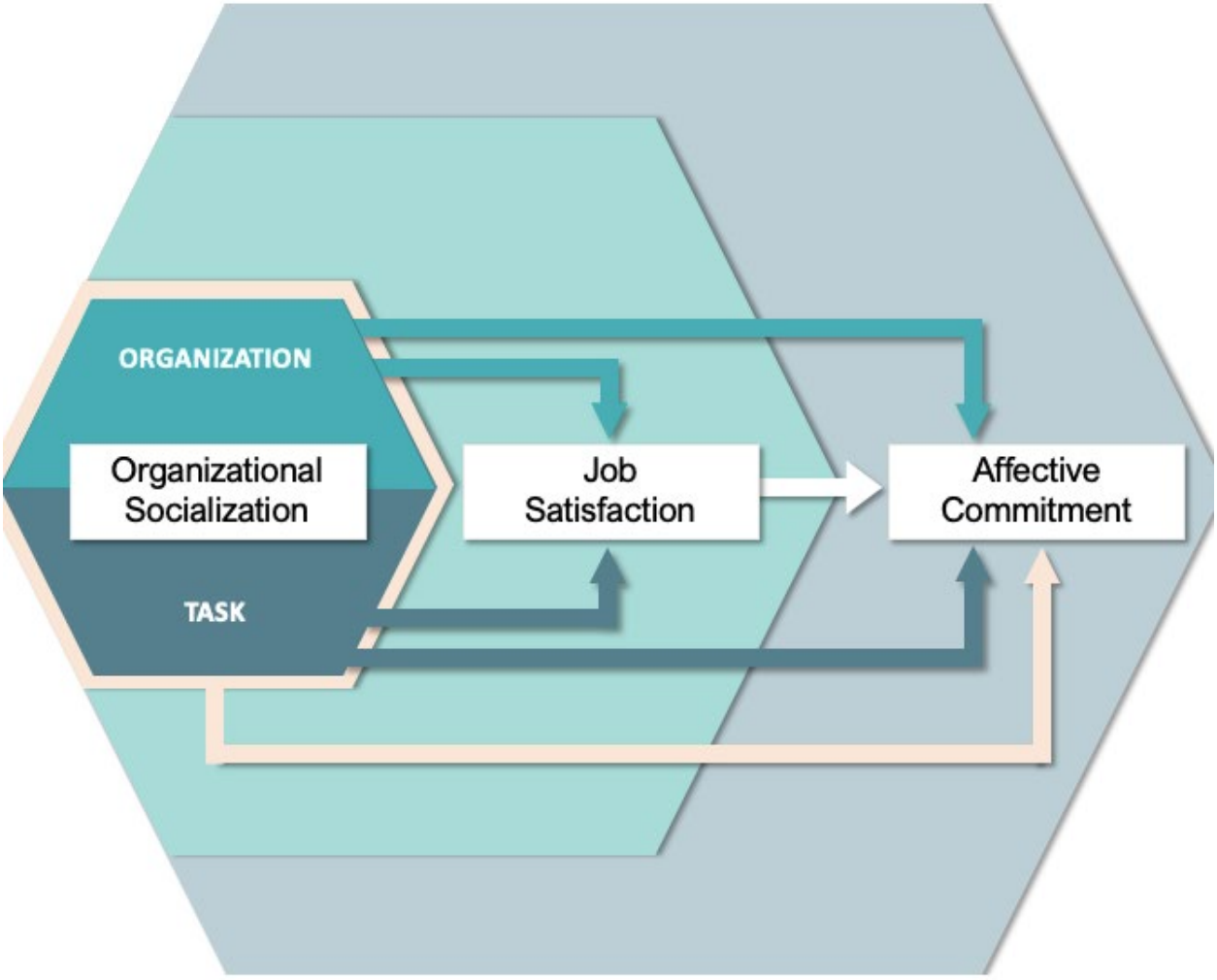
In this study, I am exploring several variables that relate to retention. These variables are illustrated in Figure 1. The conceptual framework demonstrates the potential associations between three different variables: organizational socialization (i.e., composed of task and organization), job satisfaction, and organizational commitment. Validated instruments were used to measure these constructs in this study.

Within the study, the relationships between the variables were measured through a survey. The survey consisted of three separate instruments and demographic information. Organizational socialization was measured through a 35-item Newcomer Socialization Questionnaire (NSQ) developed by Haueter et al. (2003). Job satisfaction measured using Spector's (1985) Job Satisfaction Survey (JSS) and Meyer and Allen's (1991) Organizational Commitment (OC) Scale driven by their three-component model (TCM). The NSQ instrument includes three subscales (i.e., group, organization, and task) and assesses employee attitudes and behaviors about their new position. For this study, two of the three facets were used for analysis (i.e., organization and task). The JSS is a 36-item scale with nine subscales that assesses employees' attitudes about their job. Lastly, organizational commitment was measured by using the OC Scale, a 24-item questionnaire with three subscales of normative, continuance, and

affective commitment. For this study, only the affective commitment subscale was included. All three instruments use Likert-type scales.

Figure 1

Conceptual Framework



Note. This illustration depicts linear relationships between the independent variable (i.e., task and organization, organizational socialization job satisfaction) and dependent variable (i.e., job satisfaction and affective commitment) mediated by job satisfaction.

Theoretical Framework

According to Grant and Osanloo (2016), theoretical frameworks are the backbone for providing support and structure to any research study. Van Maanen and Schein's (1977) organizational theory, Herzberg's (1959) two-factor theory, and Meyer and Allen's (1991) three-component model were used as the primary frameworks guiding this study. These theories have been used in various studies measuring the constructs considered in this study across different industries. These theories were chosen because they complement each other and provide a comprehensive approach to ascertain relationships between organizational socialization, job satisfaction, and commitment.

Van Maanen and Schein's organizational theory provides one of the theoretical frameworks for this study. The authors define organizational socialization as the process of "an individual acquiring the social knowledge and skills necessary to assume an organizational role" (1977, p. 3). Organizational socialization includes specific activities organizations may offer to their newly hired staff to assume their new role (Chao, 2012) and allows staff to socially connect with other employees and form new relationships for success (Bauer et al., 2007; Klein & Polin, 2012). Prior research has shown this process promotes better outcomes for staff and organizations (Bauer et al., 2007; Fang et al., 2011; Klein & Polin, 2012). Van Maanen and Schein's (1977) theory of socialization offers a structured process of transitioning new staff from outside of the organization to acquiring membership within the organization. Their theory is applicable across a variety of professions and workplace settings regardless of whether they are private or public. Furthermore, the theory postulates when new employees begin their positions, they often feel anxious, scared, and lonely due to deficient knowledge of existing norms, cultural values, and aspects of their roles (Van Maanen & Schein, 1977). Effective socialization has been

linked to work motivation, job involvement, organizational commitment, low turnover, innovation, job satisfaction, and cooperative behavior (Allen, 2006; Allen & Shanock, 2013; Ashforth et al., 2007; Van Maanan, 1977). During this process, both the organization and the employee are engaged in certain actions to ensure effective socialization (Tuttle, 2002). As shown in Table 1, Van Maanen and Schein's (1977) theory offers six socialization tactics to help newcomers settle into their positions.

Table 1

Van Maanen and Schein's Six Tactics of Socialization

Category	Group 1	Group 2
Collective vs. Individual	**Collective** Activities, training, and orientation offered before any actual work that the new staff engages in.	**Individual-**These activities are focused on building individual relationships. New staff are assigned a mentor. Appropriate for complex positions
Formal vs. informal	**Formal-**Activities focus on separating the new staff in activities that they must engage in prior to engaging in any type of organizational role. New staff are identified as being new staff. This tactic can result in new staff absorbing the existing culture within the organization.	**Informal** Absence of organized activities that new staff engage in. Instead, they learn by engaging in their work. As a result, new staff will be less likely to carry previously existing attitudes.
Sequential vs. random	**Sequential-**Steps provided to new staff about a specific timeline to about planned socialization activities.	**Random-**Lack of information about any potential socialization plan
Fixed vs. variable	**Fixed-**Specific timeline to completing the socialization stipes	**Variable-**Lack of a specific timeline for the completion of socialization stages
Serial vs. disjunctive	**Serial-**Role model, a mentor will be assigned	**Disjunctive-**Sink or swim attitude no specific individual will be assigned
Investiture vs. divestiture	**Investiture-**Providing support by accepting prior characteristics that new staff bring with them	**Divestiture-**Lack of support from existing staff

Note. This table lists the different tactics organizations can use to help newcomers adjust to their new positions. Adopted from Van Maanen and Schein (1977) and Jones (1986).

Successful socialization practices have been positively associated with staffs' job satisfaction, commitment, and intent to stay (Ashforth & Saks, 1996; Jones, 1986; Van Mannen & Schein, 1977). Haueter et al. (2003) reported previous research has attempted to quantify the results of socialization tactics on both satisfaction and job commitment instead of measuring the results of the socialization. The authors argued that emphasis needed to be focused on measuring employees "learning, inclusion, and assimilation" (p. 22).

In the context of the FFS compensation model, Van Maanen and Schein's (1977) theory is represented in the philosophy that OMHCs use. In reference to the theory's six tactics, FFS clinic practices align with informal socialization tactics, such that socialization practices are more heavily exercised on behalf of the individual clinician compared to the organization. Staff work independently and manage their own caseloads. The theory posits that, in the absence of formal socialization, individuals are forced to seek information independently and innovate (Van Manaen & Schein, 1977). However, even in organizations with no formal practices, staff report to their offices, seek out information, or learn through observation and listening to other staff. This often does not apply to FFS clinics as therapists work independently and manage their caseloads from home. For example, FFS clinicians are not exposed to hearing or sharing challenges with others in the lunchroom or near the watercooler. Instead, every interaction must be planned and scheduled. In the absence of formal training, lack of potential mentors, inability to share and learn ideas, and increased focus on individual productivity, staff feel overwhelmed and lost. Lacking support, formal training, and no one to provide guidance, staff often feel disappointed and ultimately seek other opportunities. Clinicians working in OMHCs experience disconnect from physical offices via remote work, and with the COVID-19 stay-home orders, organizations had to learn new ways of recruiting, hiring, and onboarding employees. For

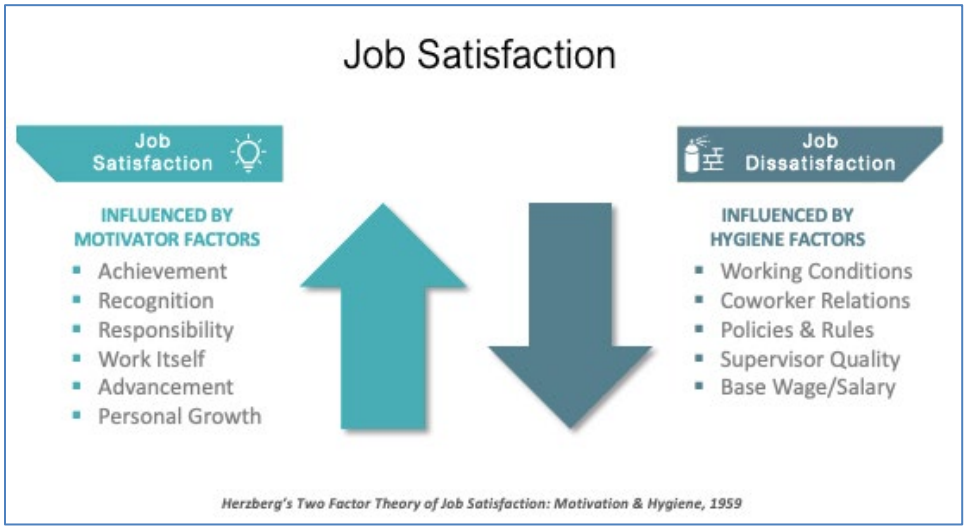
OMHCs, this was a challenge that impacted longevity and productivity. COVID-19 further increased the gap between clinicians and their ability to form meaningful connections with other therapists and their supervisors. This extra strain, combined with the increased decline of clients' mental health due to fear of infection and increased racial tensions, further decreased job satisfaction and commitment. Based on the discussion provided, OMHCs may benefit from considering collective, formal socialization practices to positively impact satisfaction as opposed to informal and individualized practices. This theory offers a model to use in organizational socialization and, when coupled with Herzberg's job satisfaction theory, affords the opportunity to test the hypotheses of this study.

A second theory used in this study is Herzberg's two-factor theory (1959) depicted in Figure 2. The theory focuses on employee motivation and job satisfaction factors. This theory posits that job satisfaction depends on two factors: motivators/satisfiers and hygiene factors/dissatisfiers. The motivator factors include achievement, recognition, job status, responsibility, and opportunities for growth. Hygiene factors include company policies, supervision, relationships, work conditions, salary, and security. Motivators are generally intrinsic and hygiene factors are typically extrinsic. Herzberg (1959) distinguished between intrinsic and extrinsic facets of job satisfaction. The underlying premise of this theory suggests job satisfaction increases intrinsically when staff feel recognized for their work, supported, and find meaning in what they do. However, staff who do not have support, have low salaries, or poor peer relationships are often dissatisfied with company policies and are more likely to feel dissatisfied with their jobs. Increases in motivation factors can improve intention to stay, while increases in hygiene factors could decrease staff's intention to stay. Notably, compensation has

been considered both a motivator and a hygiene factor. However, FFS clinics recognize compensation as a motivator factor.

Figure 2

Herzberg Two-Factor Theory of Motivation and Satisfaction



Note. Figure 2 lists motivator factors that are strong predictors of job satisfaction, while hygiene factors may predict decreased satisfaction.

In FFS clinics, great emphasis is placed on Herzberg's (1959) motivator factors: productivity, flexibility, and autonomy. Additionally, FFS organizations have adopted the concept of high compensation's positive effect on job satisfaction (Schweitzer et al., 2013), while hygiene factors drive satisfaction down. Certainly, several factors contribute to poor job satisfaction in the FFS industry including lack of compensation for cancellations and no shows, excessive driving, and lack of ongoing in-person support from supervisors and peers. Being an organizational leader within FFS clinics and listening to dissatisfied staff about the aforementioned issues, staff have also complained about lack of teaming with peers and excessive driving for which they do not get reimbursed. The recent COVID-19 pandemic and

associated stay-at-home orders have changed service delivery methods for both clients and clinicians. Telehealth services have replaced all in-person visits starting in March of 2020 and expanding through 2021. Telehealth services have eliminated driving, a major dissatisfier for FFS clinicians. The spread of the virus and inability to attend in-person supervision sessions have increased the dependency on virtual meetings for consultation and supervision. Depending on the future of telehealth, FFS clinics should revisit ways to engage and motivate staff.

Research has identified compensation as both a motivator and a dissatisfier. As mentioned earlier, FFS clinics highlight high compensation and individual productivity to attract employees for these positions. However, compensation alone is an insufficient motivator (Chamberlain, 2017). Though the promise of higher pay is motivating for FFS clinicians, if they are not offered the proper strategies to earn these promised salaries and struggle with their no shows and cancellations, then compensation becomes a dissatisfier. Therefore, if organizations desire delivering the promised high compensation for their staff using this business model, they can benefit from supporting staff and focusing on addressing Herzberg's (1959) hygiene factors as they relate to issues FFS staff encounter. Leaders might also want to consider offering to both new and existing staff initial and ongoing socialization opportunities to increase staff's intrinsic needs for support, value, and connection. Insufficient socialization practices can perpetuate feelings of uncertainty. Poor support with no clear path to success may result in staff feeling unwelcome and unsupported. Lack of clarity produces dissatisfaction and, subsequently, poor commitment. Herzberg's (1959) theory suggests motivation and satisfaction are not mutually inclusive. That is, removing all dissatisfiers does not necessarily generate satisfaction; rather, it simply reduces dissatisfaction. This is also true for motivator factors, such that removing motivators does not necessarily produce dissatisfied staff, but it does reduce satisfaction.

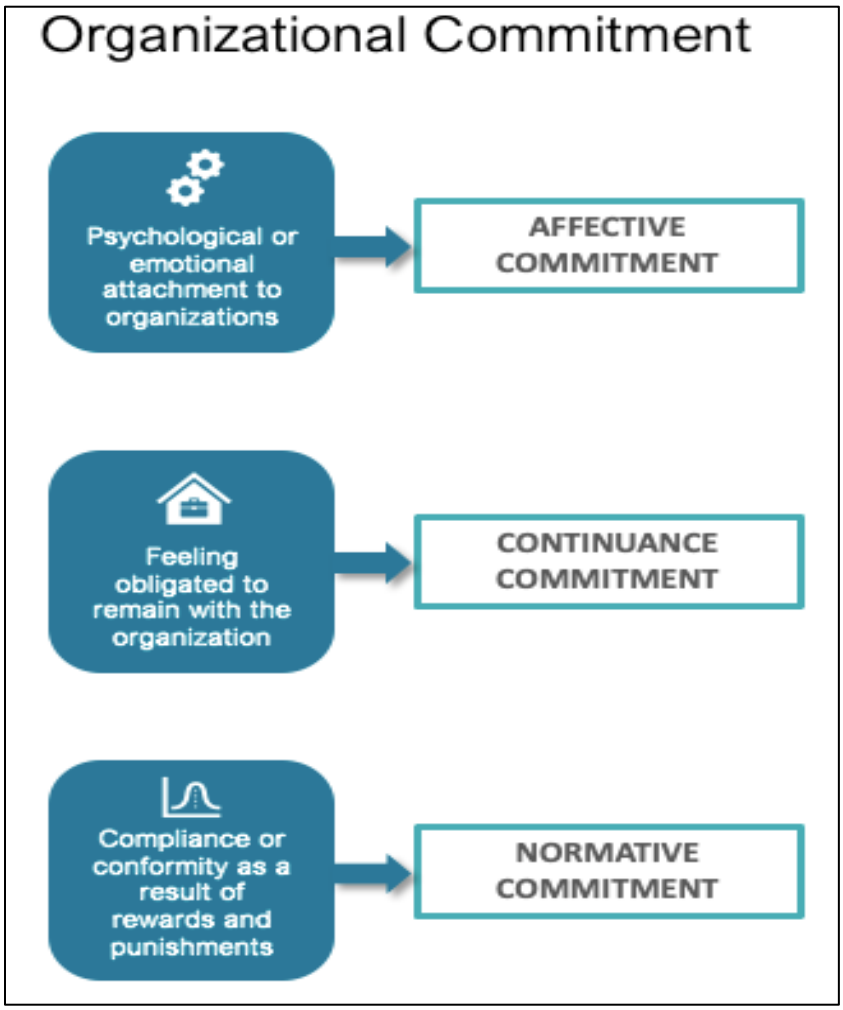
Therefore, FFS organizations need to recognize this phenomenon and take charge in being creative in their socialization practices. The socialization activities may need to extend beyond the traditional delivery of human resources paperwork by adding a comprehensive delivery of specific skills pertaining to the needs of FFS positions to build relationships and cultivate increased satisfaction and commitment.

Both small and large organizations strive to have committed employees to reduce turnover and increase retention (Meyer & Allen, 2004; Maurer, n.d). Committed employees are more productive, work independently, and are more engaged (Vance, 2006). Meyer and Allen's (1991) three component model (TCM) of organizational commitment is illustrated in Figure 3. This model remains one of the more prevalent models for studying commitment across a variety of organizations (Jaros, 2007). The TCM model divides commitment into three separate categories: affective, normative, and continuance. For this study, only affective commitment was used as it aligned with the purpose of the study: measuring FFS clinicians desire to stay (affective commitment) as opposed to normative (obligation to stay) or continued (staying is more cost effective than leaving) commitment. According to TCM, how employees feel about their organization and their emotional state will either reinforce or weaken their commitment towards their organization (Meyer & Allen, 1997). Affective commitment is the result of feelings, perceptions, and attitudes that staff develop over time, and it is the beginning of an emotional relationship that is impacted by either positive or negative experiences. If the perception, based on experiences, values and attitudes towards their organization, is positive, then staff begin forming connections. As these feelings strengthen, employees feel being part of their organization and their decision to stay begins to shape. The opposite is development of negative feelings that result in feelings of disconnect leading to the decision to leave. This model

has been used not only to measure commitment but also to predict employee outcomes, including turnover (Meyer et al., 2002). This theory was also used as the framework guiding this study to evaluate staff's affective commitment.

Figure 3

Meyer and Allen's Three-Component Model of Organizational Commitment



Note. Figure 3 represents the model for organizational commitment. Taken from Meyer & Allen's Three-Component Model of Organization Commitment (1991). Any of the three reasons shown in the model may determine staff's decision to stay or leave. This study will only focus on affective commitment.

Purpose of the Study

This quantitative research study is both exploratory and explanatory. First, it explores the relationships between organizational socialization (i.e., task and organization), job satisfaction, and affective commitment in the FFS mental health field. The study investigated whether task and organizational practices influence employees' job satisfaction and their affective commitment. Second, the study identified common factors influencing job satisfaction for FFS clinicians. The goal of the study was to provide insight to leaders in FFS organizations on how to improve retention by exploring the relationships between these variables.

Research Questions and Hypotheses

Research questions and associated hypotheses tested for this study were as follows:

Research Question 1: What are job satisfaction factors for mental health clinicians operating in FFS organizations?

Descriptive statistics were conducted to answer the first research question. There were no hypotheses associated with this research question.

Research Question 2: Does organizational socialization impact job satisfaction of FFS mental health clinicians?

H1: Organization socialization will have a positive relationship with job satisfaction for FFS mental health clinicians.

H2: Task socialization will have a positive relationship with job satisfaction for FFS mental health clinicians.

Research Question 3: Does organizational socialization impact affective commitment of FFS clinicians?

H3**:** Organization socialization will have a positive relationship with affective commitment of FFS mental health clinicians.

H4: Task socialization will have a positive relationship with affective commitment of FFS mental health clinicians.

H5: Organizational socialization (i.e., both organization and task) will have a positive relationship with affective commitment of FFS mental health clinicians.

Research Question 4: Does job satisfaction impact affective commitment of FFS clinicians?

H6: Job satisfaction will have a positive relationship with affective commitment of FFS clinicians.

Overview of Methodology

This study investigated relationships between organizational socialization, job satisfaction, and affective commitment. The study was non-experimental, quantitative, exploratory, and explanatory research and used a convenience sample. Data on demographics, organizational socialization practices, job satisfaction, and affective commitment were collected through a self-administered survey. Licensed clinicians working in FFS clinics in the state of Maryland completed the survey. Respondents received one survey including (a) demographic, (b) the NSQ (Haueter et al., 2003), (c) the JSS questionnaire (Spector, 1985), and (d) the affective commitment subscale of the OC questionnaire (Meyer & Allen, 1991). The latter three instruments used Likert-type scales to measure organizational socialization, job satisfaction, and affective commitment.

In this study, the two facets of organizational socialization (organization and task) were independent variables predicting job satisfaction, the dependent variable. Job satisfaction also

served as an independent variable predicting affective commitment. Affective commitment was the dependent variable. Initially, licensure level, prior field experience, tenure, and one or two household incomes and salary were identified as control variables, but prior field experience and one/two household income were dropped due to poor response rate. The remaining variables (licensure level, tenure, salary) were chosen to explore potential associations between job satisfaction and commitment.

The self-administered survey consisted of 84 questions and responses were provided electronically and kept anonymous. Data were collected at only one timepoint. The constructs of organizational socialization, job satisfaction, and organizational commitment were operationalized through individual questions. Questions asked participants to report the type of organizational socialization activities they had received, the degree of their satisfaction with their current positions, and their affective commitment to the organization.

The target population for this study was licensed mental health clinicians working for FFS clinics. Two higher education institutions with graduate social work and counseling programs within the Mid-Atlantic region were contacted to share the survey with their alumni listservs. Further, Facebook and LinkedIn were used to distribute the survey. Information about the purpose of the research and importance of participant feedback to the field was provided. Additionally, the voluntary, risk-free, and confidential nature of the survey was explained. The survey link was uploaded and reposted every other day for various professional groups on Facebook, LinkedIn, and the various professional groups to increase participation rate. Respondents who agreed to participate in the study provided their consent by selecting “next” to begin the survey. The eligibility criteria for the study included possessing specific licensure and working in FFS settings within the State of Maryland.

The independent variables were organizational socialization (i.e., task and organization socialization predicting job satisfaction) and job satisfaction (i.e., predicting affective commitment). The dependent variables were job satisfaction (i.e., outcome of organizational socialization) and affective commitment (i.e., outcome of job satisfaction). Employees 'attitudes and behaviors were measured to capture each construct. Initially, covariates included licensure, income, tenure, prior experience, and whether participants come from one or two household incomes.

Significance of the Study

This study is significant as it will facilitate leaders within FFS clinics to understand the potential relationships between organizational socialization, job satisfaction, and commitment. The study aims to identify common factors contributing to job satisfaction for FFS clinicians. The premise of this study is the assumption that improving new employees' organizational socialization could increase their job satisfaction and commitment, ultimately leading to improved retention. Only through increased job satisfaction can organizations be successful (Latif et al., 2013). Furthermore, the results of this study can provide a better understanding of what organizations can do to increase satisfaction and commitment. Findings may also shape curricula in higher education to add business content in addition to clinical courses to better prepare graduates to gain knowledge and understanding of business acumen.

Organizational socialization, job satisfaction, and organizational commitment are constructs that have been examined extensively across many fields. Within the mental health field, studies have examined organizational socialization, job satisfaction, and mental health providers' commitment in public agencies, hospitals, and schools. These studies have identified and highlighted a variety of factors that negatively impact job satisfaction and commitment and

ultimately produce high turnover, including inefficient organizational socialization practices (Allen, 2006; Bauer, 2010), lack of autonomy (Morse et al., 2012), high caseloads (Galofaro, 2015), and poor wages (Schweitzer et al., 2013). Few studies have addressed how organizational socialization can influence job satisfaction and FFS mental health clinicians' commitment. Additionally, little is known about common factors that contribute to job satisfaction for FFS clinicians. This study aimed to fill that gap by identifying common predictors of job satisfaction and their impact on commitment. Finally, the purpose of the study was to examine the role of both organization and task socialization and their relationship with job satisfaction and commitment.

Limitations

The limitations of the study include the cross-sectional, quantitative design of the study and the sample. In addition to the two universities, the study used Facebook, LinkedIn for recruitment contributing to potential sampling bias, as the survey was limited to only alums of the two universities and individuals who were active on social media. Therefore, the sample may not be representative of all FFS mental health clinicians. Participants who opted to complete the survey may have been individuals who had positive experiences with their organization as opposed to individuals who had negative experiences and chose not to engage. Due to the pandemic and current events, completing a 15-minute survey with 84 questions may have added an extra burden on clinicians who were already under a great deal of stress. The time constraint may have resulted in incomplete responses to questions or forfeiting participation altogether. To limit exposure to the spread of misinformation on social media, many clinicians may have suspended their social media account and thereby missed the survey. The quantitative nature of the study may also have introduced limitations, as it cannot offer contextual understanding of the

complexity of organizational socialization, job satisfaction, and commitment. That is, a qualitative approach could provide a deeper understanding of staff's perceptions of their experiences in their place of employment. The two pandemics of 2020 and how organizations addressed them may also have influenced the way staff perceived their organization, subsequently impacting their responses about their job satisfaction and affective commitment. Other limitations include social desirability, non-response, and recall bias impacting the results of the study.

Definitions of Key Terms

To facilitate understanding of the terminology used in this study, key terms and their definitions are shown in Table 2.

Table 2

Key Terms and Definitions

Term	Definition
Affective commitment	Employees desire to stay (Meyer and Allen (1991)
Fee-for-service (FFS)	FFS is a model of compensation that pays staff a percentage of their total billing.
Job satisfaction	defined job satisfaction as a worker's positive emotions towards their job (Senter et al., 2010).
Mental health	A "dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society" (Galderisi et al., 2015, pp. 231–233).
Mental health clinicians	Mental health clinicians are individuals who have attained a master's degree in counseling (LGPC, LCPC) or social work (LMSW, LCSW_C) and are licensed to practice in the state of Maryland.
Onboarding	It is getting new employees the tools they need to help become productive and learn about the culture of the company (Maurer, n.d).
Organizational commitment	Organizational commitment is employees' feelings and attitudes about their organization that can determine loyalty (Judge et al., 2017).

Term	Definition
Organization socialization	Learning relevant information about the organization such history, goals, values, and politics (Haueter et al., 2003).
Organizational socialization	organizational socialization as the process where new employees acquire knowledge, behaviors, and attitudes within their employment (Van Maanen and Schein,1977). For this study, onboarding and organizational socialization will be used interchangeably.
Outpatient mental health clinics (OMHCs)	OMHCs are state approved clinics with specific regulations (COMAR 10.09.54.04).
Task socialization	Task socialization involves gathering information about the job and understanding the tasks associated with it (Haueter et al., 2003).

Summary

Chapter 1 presented introductory information for the research study. The background and historical evolution of mental health was briefly introduced and factors that have increased demand for mental health services were discussed in detail. The purpose of the study was identified. The goal of this research was to explore the hypotheses that organizational socialization will impact job satisfaction and organizational commitment of FFS clinicians. Additionally, this research identified common predictors of job satisfaction and their impact on affective commitment. The theoretical frameworks used to guide this research study were Van Maanen and Schein's (1977) socialization theory, Herzberg's (1959) two-factor theory, and Meyer and Allen's (1991) three-component commitment model (TCM). These theories were discussed in relation to FFS mental health clinicians and demonstrated the importance of task and organization socialization and the impact of job satisfaction on affective commitment. An overview of the methodology used in this study was introduced. This research was a quantitative, non-experimental, cross-sectional design surveying mental health clinician working in FFS clinics. The study hypotheses tested correlations between organizational socialization, job

satisfaction, and affective commitment. Lastly, this chapter discussed the significance of the study and its potential impact on mental health clinics, clinicians, and curriculum offered in higher education institutions for social work and counseling. The FFS compensation model offers flexibility, autonomy, and opportunity to earn higher wages. This model also combats preconceived beliefs that mental health clinicians should expect to work long hours and earn poor wages. Rather, organizations should offer adequate organizational socialization to enable staff to earn better wages, have greater flexibility and autonomy, and build the knowledge and skills necessary for success.

Organization of This Dissertation

This dissertation is organized into five separate chapters. This chapter introduced the study and historical background. Chapter 2 reviews literature related to the study. Specifically, it reviewed literature on the importance of organizational socialization, job satisfaction, and commitment across various industries and how they relate to each other. Chapter 3 presents the study methodology and describes the research design, sampling, measures, and data collection procedures that support the quantitative nature of this research study. Chapter 3 also discusses the statistical methods used to analyze the data. Chapter 4 provides data analysis and discusses findings and emerging themes. Chapter 5 offers results, recommendations, limitations, and implications for future research.

Table 3

Research Overview and Chapter 1 Summary

Element	Summary
Purpose of the Study	To identify the common job satisfaction factors of fee-for-service (FFS) mental health clinicians as well as the role of organizational socialization on job satisfaction and commitment of fee-for-service mental health clinicians.
Justification	Data about FFS mental health clinicians are lacking in the current literature. Due to high turnover and the nature of compensation, FFS organizations are unable to retain and acquire talent. Organizational socialization has shown to positively impact both job satisfaction and commitment.
Methodology	This study is quantitative by design and utilized a cross-sectional survey
Scope	This study examined the relationships between organizational socialization, job satisfaction, and commitment to gather data from FFS clinicians using a survey administered using demographic questions developed by the researcher, questions from NSQ (3004), JSS (1985), and TCM (1991). Data were collected from 81 clinicians in the Mid-Atlantic region.
Theoretical Framework	Three major theories were used for this study with over 50 years of combined research about organizational socialization, job satisfaction, and commitment. These theories examined psychological and behavioral issues influencing job satisfaction and commitment. The frameworks within this study include the works of Van Maanen & Schein (1979) Herzberg et al. (1959), and Meyer & Allen (1991).
Limitations	Limitations include social desirability; sampling bias; non-response bias due to Covid-19, quantitative nature of the study, and recall bias.
Contributions to existing literature	This paper contributes to prior research by providing preliminary findings about organizational socialization, job satisfaction, and commitment of FFS clinicians. It also attempts to fill in gaps in the literature by: • Examining the types of organizational socialization activities and their relationship to job satisfaction. • Confirming the importance of organizational practices and the role it has on increasing job satisfaction and commitment. • Identifying common job satisfaction factors for FFS mental health clinicians.

CHAPTER 2: LITERATURE REVIEW

This study focused on the impact of organizational socialization (i.e., organization and task) on job satisfaction and affective commitment. These constructs have been studied extensively across a variety of disciplines, including mental health. Limited research exists for both FFS clinicians and organizations. In FFS organizations, staff orientation is designed to increase productivity so that clinicians can generate greater revenue and thus enhance their compensation. It is unclear how and to what extent organizational socialization activities are offered to help staff acclimate to their new roles and whether staff are compensated for those experiences. The goal of this study was to support the assumption that in FFS organizations, a greater emphasis on organizational socialization may positively affect job satisfaction and affective commitment. Additionally, the study sought to understand common job satisfaction factors influencing affective commitment.

This chapter reviews literature on organizational socialization, job satisfaction, and organizational commitment as individual constructs. It further reviews existing research across a variety of disciplines on potential associations between these variables. Three theories (i.e., socialization theory, motivation theory, and three-component commitment theory) were used as the theoretical framework guiding this investigation. These theories provided foundational explanations on what employees need for success, what motivates them, and what factors impact their commitment. These theories also provided insight into what organizations may consider to achieve the goal of retention. Although these theories were developed decades ago at a time when globalization was less prominent, they remain relevant in more contemporary management. Organizational socialization, job satisfaction, and commitment are some of the most heavily researched constructs dating back to the Industrial Revolution. This chapter

includes review of prior research on the relationships between these constructs. Literature on FFS clinicians is limited. Specifically, very little is understood about the impact of organizational socialization on job satisfaction and commitment and how job satisfaction can potentially impact affective commitment within FFS organizations.

For the purposes of this study, socialization practices of mental health providers working in salaried positions were reviewed. Because of the lack of literature on socialization practices of clinicians working in FFS settings, careers and fields unrelated to mental health were also investigated. These included organizations that compensate staff through commissions or a percentage of sales revenue. Literature on socialization practices of commission-based industries employing sales professionals provided insight into phenomena related to organizational socialization and its associations with employee job satisfaction and commitment. Additionally, the inclusion of literature on factors that contribute to mental and non-mental health clinician's job satisfaction provided indicators of general human needs that guided research questions and hypotheses.

Sources and Methods

Literature was searched through academic databases including Psychinfo, EBSCO, and Google Scholar. I also looked for articles through Research Gate, JSTOR, Elsevir, APA, and PsychNet Key search terms included: *social workers, counselors, mental health providers, organizational socialization, onboarding, and training, organizational commitment, affective commitment, task socialization, organization socialization, job satisfaction, private practice, public clinics, fee for service, percentage-based compensation, commission-based compensation, base salary and bonus, outpatient mental health clinics*, *socialization theory, two-factor theory, the three-component commitment model*, *and talent management.* The literature search was

initially limited to articles published between the years of 2010 and the present; however, due to a lack of current studies, literature from the early 2000s was included. I also expanded my search to studies completed in other countries as organizational commitment, job satisfaction, and commitment are constructs that all organizations are interested in globally regardless of culture or country.

During my literature review, I also found limited data about clinicians working within FFS OMHCs. As a result, I sought posted clinician reviews on Google, Indeed, and Glassdoor about staff's work experiences in such clinics. I found both positive and negative comments that were relevant and further supported this research. Positive comments included acknowledgment of high compensation rates as well as the flexibility and autonomy offered by the positions. Conversely, negative comments focused on lack of organizational support and lost wages due to both cancelled appointments and excessive driving. These reviews further supported the need for this study to provide foundational data pertaining to FFS organizations.

Regarding the current research, the first part of this section introduces talent management as part of organizational socialization (i.e., organization and task), job satisfaction, and organizational commitment. In this section, organizational socialization is addressed across different disciplines. Job satisfaction and commitment are explored within the mental health field or related human services field. Additionally, literature showing the relationship between organizational socialization and job satisfaction, organizational socialization and commitment, and job satisfaction and commitment were reviewed.

The second section discusses different theories applicable to the constructs measured for this study. Van Maanen and Schein's (1977) theory of socialization, Herzberg's (1959) two-factor theory, and Meyer and Allen's (1991) TCM underpinned the study. These theories have

been cited and applied in occupational research in different countries and across fields. The constructs of organizational socialization, job satisfaction, and organizational commitment and their relations with each other have been researched. These theories are discussed both individually and in the context of how they complement each other. This chapter concludes with a summary of a discussion supportive of the research questions this study posed.

Theoretical Framework

Van Maanen and Schein's (1977) theory of socialization was one of the primary theoretical frameworks used to guide this study. Although prior theorists have discussed organizational socialization, Van Maanen and Schein (1977) are considered the forefathers of organizational socialization theory. According to the theory, organizational socialization is the process of transitioning new staff from being outsiders to insiders (Allen et al., 2017; Van Maanen & Schein, 1977). The transition period is a time where staff begin developing value-related concepts about their organization (Chao et al., 1994). During this phase, organizations can offer specific actions, displayed in Table 1 in the previous chapter, to facilitate newcomer learning. These include individual informal tactics and collective formal tactics. Van Maanen and Schein (1977) postulate that the two sets of socialization tactics would generate different role responses that are on opposite ends of the spectrum. On one side is the custodial role response, and on the other side is the innovative role response. The authors suggest that, when organizations offer individualized informal socialization tactics, individuals become more motivated to problem solve and become innovative, as opposed to assuming the custodial role response socialization. According to the theory, when staff are offered formal collective socialization theory, they might take on the attitudes of prior employees and be less inclined to be innovative.

A few years later, Jones (1986) condensed Van Maanen and Schein's (1977) six tactics into three separate groups based on the functions they served. These included contextual group responses (i.e., collective-individual and formal-informal), content responses (i.e., fixed-variable and sequential-random), and social responses (i.e., investiture-divestiture and serial-disjunctive). Jones (1986) placed socialization tactics on opposite ends of a continuum, with the far-left side labeled as "institutionalized "socialization and the far-right side labeled as "individual" socialization. Contextual tactics include formal trainings that set expectations and explained policies and individualized tactics including removing training to leave employees to learn on their own. Content tactics refer to the structure of what organization offer such as a blueprint of the training agenda and a timeline versus no training agenda (Van Maanen & Schein, 1977). Social tactics provide support and mentoring or leave new staff with no support.

Van Maanen and Schein's (1977) theory has received criticism. For example, Tuttle (2002) argued the theory, developed between the 1960s and 1970s, is outdated and in need of updated research across different fields. Lynham (2000) suggested testing different parts of the theory is insufficient; rather, researchers need to examine new evidence to support the theory. Additionally, although Van Maanen and Schein's (1977) work is well cited, Tuttle (2002) reported no one had truly compared their results with the theory's viability. She suggested, based on the vast research that currently exists, changes to the theory's assumptions and models might call for a new model. Despite these criticisms, the theory has been used extensively over the last 40 years. Additionally, use and discussion of Van Maanen and Schein's (1977) theory has been pervasive throughout literature on personnel socialization. Almost every theory established after Van Maanen and Schein's theory was proposed has used their seminal work in some context. Haueter et al. (2003) argued organizational socialization includes three separate domains:

organization, task, and group socialization and developed an instrument to measure organizational socialization. In this study, organizational socialization will be operationalized as both organization and task socialization. Group socialization facet will not be used within this study due to the autonomous nature of the position. FFS clinicians do not have the capability of learning through group socialization as most of the work takes place independently out in the field and not in a group or office setting. Therefore, the opportunity to learn from others organically is not possible. For these reasons, the group socialization facet will not be utilized in this study. Van Maanen and Schein's (1977) socialization theory offers a model that organizations can use and, when coupled with Herzberg's (1959) two-factor theory, it affords an opportunity to test the hypotheses for this study.

Herzberg's Two-Factor Theory

Herzberg's (1959) two-factor theory was the second framework used to guide this study. The theory addresses both motivation and job satisfaction, postulating two sets of factors in an individual's workplace that increase or decrease job satisfaction (Herzberg, 1959). Herzberg developed this theory to examine job satisfaction and its relationship to organizational commitment. As discussed in Chapter 1, Herzberg's theory (1959) provides hygiene and motivator factors that either increase or decrease job satisfaction. The theory cautions against treating these two factors as opposites. That is, the opposite of satisfaction is not dissatisfaction but rather no satisfaction. Similarly, the opposite of dissatisfaction is not satisfaction but no dissatisfaction (Herzberg, 2010).

Although, this theory dates back to the 1950s, it is still relevant (Giese & Avoseh, 2018; Lukwago et al., 2014; Stello, 2011). The theory was originally used with engineers and accountants; however, over the years, it has been applied across a variety of industries and

countries (Busatlic & Mujabasic, 2018; Stello, 2011). The theory however has been criticized by numerous scholars. Gaziel (1986) compiled many of the criticism as follows:

> (a) The theory appears to be method bound, (b) the theory confuses the event or condition that causes the employee to feel satisfied or dissatisfied with the agent (person, organization, or thing) that caused the event to come about, (c) Herzberg's results particularly for the hygiene factor, support the notion that there might be an artifact of ego-defensiveness on the part of the employee, (d)There was some overlapping of factors as sources of satisfaction and dissatisfaction, (e) the value of the two kinds of factors differed as a function of occupational level of the employee, and (f) the characteristics for sources of satisfaction and dissatisfaction were overlapped; depending on role or position of an employee the value of job satisfaction factors differed from one employee to another (Gaziel, 1986, p. 615).

Despite Gaziel's criticism of Herzberg's theory (1959), Stello's (2011) literature review supported the theory's relevance. Further the model has been used across various industries including education (De Shields et al., 2005), hospitality and tourism (Lundberg et al., 2009), mental health nursing (Holmberg et al., 2017), and child welfare (Bednar, 2003). These studies applied Herzberg's (1959) two-factor theory to the constructs of job satisfaction and organizational commitment and validated that focusing on motivator factors increased satisfaction. insalso highlighted the need for leaders to focus on motivator factors instead of hygiene factors to increase motivation, as improved hygiene factors cannot become motivators and can only decrease rather than eliminate dissatisfaction. Although the theory has been used across various industries, it has not been applied to clinicians in FFS organizations.

In FFS organizations, the two-factor theory may clarify the construct of job satisfaction and how it may potentially relate to organizational commitment. The theory posits motivators can be strong predictors of job satisfaction, so if leaders focus on providing adequate support, recognition, relationship building opportunities, and a sense of belonging to their clinicians, they may ultimately increase motivation. This aligns with the theory's premise that increased motivation is related to satisfaction and commitment. Prior research has considered pay or compensation as both a motivator and hygiene factor. There is inconsistency among previous and current literature about the role of pay in satisfaction and commitment. Historically, pay has been considered an extrinsic motivator with a negative impact on satisfaction and commitment (Cameron, 2001, Chammorro-Premuzic, 2013; Deci et al., 1999). Human service workers typically do not choose the profession for its pay; instead, they desire to help or be role models for others (Woodside & Mc Clam, 2011). Rynes et al. (2004) found in self-reported surveys, most human service workers underreport the importance of pay as a motivator. The authors agreed this assumption is based on a variety of factors and varied according to individuals and circumstances. Schweitzer et al. (2013) surveyed social workers across different work settings, including FFS outpatient settings, and found compensation was one factor that predicted job satisfaction. The same study revealed people favor salaried positions more than FFS for job security and stability reasons. Regardless of these findings, Chamberlain (2017) reported providing competitive wages to staff as one way to ensure staff remain in their current roles. When staff in FFS clinics are promised high salaries without proper organizational socialization practices, they may begin to feel insecure about their job stability and potentially develop poor relationships with their leaders. These experiences should increase dissatisfaction and potentially reduce commitment. However, if pay is adequate and staff feel connected, recognized, and

supported, their job satisfaction and decision to stay should increase. This study will examine the relationships between organizational, job satisfaction, and commitment. It may also serve as an incentive for leaders within FFS clinics to tune in to the needs of existing staff to improve organizational processes. With the growing needs of the mentally ill (NAMI, 2019) and the shortage of mental health providers (Health Resources Services Administration, 2016), the Meyer and Allen's (1991) three-component model (TCM) provides the framework for staff's organizational commitment.

Meyer and Allen Three-Component Model of Commitment

Meyer and Allen's (1991) TCM theory also served as a framework guiding this study. Organizational commitment is not a new phenomenon. Indeed, it has been extensively studied across mental and non-mental health disciplines (Abdallah et al., 2017; Aranki, et al., 2019; Jaskyte & Lee, 2009; Meyer et al., 1993; Supriati & Furkan, 2019), According to Meyers and Allen (1987), organizational commitment has been studied through the lens of two different theories: affective attachment theory (Mowday et al.,1979) and side-bet theory (Becker, 1960). Mowday et al. (1979) conceptualized organizational commitment as an affective attachment or the degree to which employees can identify with their organization and the magnitude of their level of involvement. Further, Mowday et al. (1979) developed the organizational commitment questionnaire (OCQ) that measures affective organizational commitment to ascertain if employees accepted organizational goals, were willing to work hard, and whether they wanted to stay. Becker's (1960) theory of commitment suggested staff remain engaged in their employment because they recognize the costs of leaving. Finally, Wiener (1982) suggested staff remain in their employment due to moral obligation.

Meyer and Allen (1991) combined these separate theories and developed the TCM to measure organizational commitment. The premise of this theory is that employees experience internal commitment that impacts their decision to stay or leave their place of employment. According to the TCM, organizational commitment is defined as a "psychological state of an employees' relationship with their organization and their decision to continue or discontinue membership in the organization" (Meyer & Allen, 1991, p. 67). The authors further identified three separate types of commitments (affective, continued, and normative) that influence an employee's decision to stay or leave. They postulated there are different reasons people stay within their organizations. Meyer and Allen (1991, 1997) summarized employees' perspective of their relationship to the organization can be explained through the feelings and emotional attachment employees have toward their job (i.e., affective), their moral obligation to stay (i.e., continuance), and the benefits they receive (i.e., normative). These reasons align with this theory's premise and provide an understanding of why employees stay. Jaros (1991) agreed the TCM examines how the employee perceives organizational commitment. For this study, only affective commitment will be explored as organizational commitment. Due to the exploratory nature of this study, the focus of the study was to examine the relationships between job satisfaction and whether it had any association with clinicians' desire to stay.

Although the TCM has been regarded as a leading model for measuring organizational commitment (Meyer et al., 2002), it has also been criticized. Solinger et al. (2008) argued the model is "inconsistent and that affective, normative, and continuance commitment cannot be considered as components of the same attitudinal phenomenon" (Solinger et al., 2008, p.70). Solinger et al. (2008) further postulated the TCM predicted turnover but not necessarily

commitment. Despite these critiques, the selection of the TCM model is appropriate for this study as it seeks to explore the affective commitment of staff in FFS organizations.

Before discussing the study variables, it is important to review the role of human resource professionals within organizations and the process of recruitment and talent management. Although recruitment is not part of this study, it is important to understand its relationship to the organizational socialization practices and retention process.

Talent Management

According to Lewis and Heckman (2006), the phrase, talent management, has different definitions and meanings. The Society for Human Resource Management (SHRM) defines talent management as "strategies designed to attract, develop, retain, and use employees with the necessary skills and aptitude to meet business current and future needs" (Gurchiek, 2006, para.3). Coker (2019) maintained talent management is more than just a term— it is the "commitment an organization has in hiring, managing, developing, and retaining extremely talented individuals" (para.1). Waiting until the exit interview to assess reasons for leaving can be considered too late for long-term staff sustainment (Florentine, 2019). Instead of waiting to assess reasons for leaving, employers can draw on the existing empirical data that identifies proper recruitment efforts, socialization practices, and motivating employees with opportunities that increase job satisfaction and commitment within different industries (Allen & Shanock, 2013; Baggerly & Osborn, 2006; Bartlett & Kang, 2004; Bauer, 2010; Bauer et al., 2007; Brat et al., 2012; Coker, 2019; Gurchiek, 2006). With increased satisfaction and commitment, organizations of various industries can increase retention (Asegid et al., 2014; Barak et al., 2001; Brown et al., 2019; Carbery et al., 2003; Chamberlain, 2017; Chen et al., 2011).

Variables

Organizational Socialization

Before addressing the importance of organizational socialization practices, it is critical to understand what these practices are and whether they differ across various industries. Certainly, an important objective was to find and review organizational socialization that would apply to FFS mental health clinicians. However, a void exists in the literature with no discernable discussion of socialization practices unique to FFS or mental health agencies. As a result, non-mental health commission-based sales industry, nursing, and mental health fields were explored to find patterns of effective socialization practices

Organizations participate in many practices when new employees begin their positions. Activities such as orientation, onboarding, and organizational socialization have been used to describe the process. The research on organizational socialization dates back to over 50 years (Allen et al., 2017). Van Maanen and Schein (1977) offered one early definition of organizational socialization as the "process by which an individual acquires the social knowledge and skills necessary to assume an organizational role" (p. 211). Based on this definition, the theory of organizational socialization was founded. Many other scholars have since expanded on the definition of organizational socialization in their research. For example, Bauer et al. (2007) described organizational socialization as the "process by which newcomers make the transition from being outsiders to being insiders" (p. 7). Acevedo and Yancey (2011) stated that the purpose of organizational socialization is to "increase new employees' knowledge, skills, and abilities" (p. 349). Although organizational socialization has been extensively studied (Abu-Doleh & Obediat, 2018; Allen et al., 2017; Bauer, 2010; Bauer & Erdogan, 2012), it continues to impact the field of organizational psychology. Based on this research and the demand for

employees, organizations that want to remain competitive in the current market may benefit from attending to their socialization process (Nasr et al., 2019) and the influence it can have on retention (Barak et al., 2001; Bauer et al., 2007; Carucci, 2018) and commitment (Madlock & Chory, 2014).

Another term often used interchangeably with organizational socialization is onboarding. Bauer and Erdogan (2012) defined onboarding as a "process that helps new employees learn the knowledge, skills, and behaviors they need to succeed in their new organizations" (p. 51). Klein and Polin (2012) disagreed and postulated that onboarding and organizational socialization are not interchangeable but are rather distinct constructs. The authors defined onboarding as "formal and informal practices, programs, and policies enacted or engaged in by the organization or its agents to facilitate newcomer adjustment" (p. 268). Chao, (2012) divined the term as an ongoing process that lasts throughout employees' tenure with their organization (Chao, 2012,). In this study, Chao's (2012) definition will be adopted, but the terms will be used interchangeably. Organizational socialization will be defined as organizations offering initial tactics and ongoing support to help new staff be successful and remain engaged, satisfied, and committed throughout their employment.

According to Haueter et al. (2003), organizational socialization can be subdivided to three different components: organization socialization (OS), group socialization (GS), and the task socialization (TS). Each component measures different factors of the socialization process. For example, TS refers to the knowledge gained about the specific job duties, OS is learning about the culture, history, goals, rules, and politics (Madlock & Chory, 2014). For this study, OS and TS were utilized, while GS is not relevant to FFS clinicians as much of their organizational socialization revolves around task and organization socialization.

According to the U.S. Bureau of Labor and Statistics (2019), the average individual transitions 12 times to a new job in their lifetime. Reasons for transitioning to new positions include seeking better pay, career advancement, work-life balance, lacking skills and abilities required by the job, and many more (Doyle, 2020). The labor statistic is indicative of how important organizational socialization is for organizations to ensure staff receive the skills they need for success. Failure to provide the necessary socialization can result in failed employee expectations leading to high turnover. According to Bauer (2010), "30% of organizations spend little time in thinking about their onboarding process, 50% spend time and effort on their onboarding process but do not see it as strategic initiative, while the remaining 20% of firms engage in proactive onboarding" (p. 3). Many organizations engage in different organizational practices based on theories and accepted research. Organizational tactics are actions both a new employee and the organization partake in to ensure effective transition (Saks et al., 2007; Van Maanen & Schein, 1977). Organizational socialization promotes the successful adjustment of new staff (Tuttle, 2002). Once this process is successfully achieved, performance may increase, and staff potentially will adjust to their new work environment. Soon after adjusting to their new role, they may begin to feel accepted by the other employees. Then they become capable of achieving new tasks (Bauer et al., 2007).

Different industries implement formal, planned, structured, unstructured, and informal socialization practices. Regardless of the type of organizational socialization, the purpose is to help newcomers learn the culture, workplace norms, and their roles (Ashforth et al., 2007; Saks et al., 2007; Van Maanen & Schein, 1977). Existing research has affirmed that organizational socialization tactics reduce staff's anxiety, allow for better adjustment, and increase satisfaction and commitment (Bauer & Erdogan, 2014; Jones, 1986; Nasr et al., 2019; Van Maanen &

Schein, 1977). As discussed earlier, Van Maanen & Schein's organizational socialization theory offers both formal and informal socialization practice but posit that, in the absence of formal socialization, individuals who are "on their own" can learn and become innovative. Despite this argument, meta-analyses about effective socialization practices have shown that institutionalized tactics result in greater role clarity, higher job satisfaction, and increased commitment (Bauer et al., 2007).

Historically, many traditional theories have focused on benefitting organizations instead of employees. Due to advancements in organizational behavior, newer studies have focused on the needs of employees more than what benefits organizations (Lacaze & Bauer, 2014). Markets have become more competitive, and retaining staff is an ongoing challenge. To address these ever-changing issues, organizations may want to promote a culture of tolerance and acceptance in the workplace. Global changes, such as shortage in human capital, problems with retention, and job mobility, have influenced traditional relationships that existed between companies and their staff. Organizations are aware hired staff may not stay with them permanently, and that, at any point, they may opt to find new positions (Lacaze & Bauer, 2014). In the current market, both employer and employee understand either party can terminate the working relationship (Lacaze & Bauer, 2014). FFS organizations are prime examples of this evolution with the greatest challenge of onboarding and retaining the right staff. To increase retention and reduce turnover, FFS organizations may need to examine their socialization practices to elevate satisfaction and commitment. Spending more time on the process of socialization has been linked to increased job satisfaction (Carucci, 2018), and providing formal socialization practices reduced turnover (Pike, 2014). Based on literature about organizational socialization and its importance for increasing job satisfaction and commitment, the next sections provide evidence

that regardless of the industry, socialization practices are more similar and are based on organizational socialization theories.

Mental Health Field

Abramson (1993) evaluated traditional orientation practices offered to social workers and discussed the importance of socialization over time. She reported the first few weeks on the job often include introductions, individual time to read manuals, a tour of the work setting, and possible discussion of the mission and vision of the organization while also receiving caseloads and guidance from supervisors. Abramson reported these one-time cited practices were unsuccessful. Instead, she offered strategies for more effective ways to orient staff to their new positions. Abramson (1993) suggested these activities be delivered on multiple occasions over time to increase commitment and retention. As such, it is possible that challenges of retention and personnel shortages in the mental health field may be related to outdated methods of staff onboarding and not just low wages, high stress, and lack of autonomy (Abramson, 1993). Although Abramson's argument is over 30 years ago, recent studies support her discussion by encouraging organizations to offer a comprehensive socialization process that is institutionalized and includes structured processes or activities (Bauer & Erdogan, 2011; Klein & Polin, 2012).

Another important aspect to consider is the length of time that employees spend when engaging in socialization practices. Acevado and Yancey (2011) for example, compared Western orientation models to Japanese models of onboarding and found two significant differences. In the Japanese model, employees' orientation lasted anywhere between 6 months to 3 years, while the Western model only required employees to complete paperwork before performing their duties. Mestre et al. (1997) added to the discussion that within the Japanese model individuals were not hired for specific jobs but as entry-level employees. According to this model, the

purpose is to cross train employees and integrate them within the organization. This process allows new employees to learn different functions and departments to positively impact teamwork and productivity. In contrast, the Western model hires employees for specified positions without much cross training unless they get promoted to a different department. Acevado and Yancey (2011) found another difference between the two models which was the lack of evaluation for Western orientation models and its influence on new employees. Although the Japanese model may be impractical in many professional industries, the concept of providing longer time periods for socialization has been linked to increased job satisfaction and affective commitment (Barak et al., 2001; Bauer et al., 2007; Bauer & Erdogan, 2012).

Nursing Field

Similar to the mental health field, the nursing industry is another health-related vocation with high turnover rates attributed to lack of support, lack of schedule control, increased employment opportunities, and challenging work atmospheres (The University of New Mexico, 2016). Lack of proper onboarding tactics has been associated with poor retention (Kurnat-Thoma et al., 2017). The importance of proper socialization of nurses is also associated with increased retention (Kurnat-Thoma et al., 2017; Nursing Solutions, 2016; Tomietto et al., 2015).

Non-Mental Health Fields

There are many sales careers in the United States in which employees earn their income through commission and are paid for performance. Sales engineers, real estate broker/sales agents, financial advisors, sales managers, and securities and financial services agents were ranked as the top five commission-based positions (Study.com, 2020). These occupations are sales driven, and compensation is based on sales. Limited scholarly literature was found regarding the topic. As a result, newspaper articles and blogs were reviewed to gather

information about similarities with FFS organizations. Weiss (2019) argued that if organizations want successful sales, they may want to invest in preparing their employees with the necessary tools and skills to increase their sales. Weiss also offered practical steps for onboarding sales professionals, including skill building, providing support and mentoring (Thomas, n.d.), promoting autonomy (Weiss, 2019), and setting real expectations (Thomas, n.d.). Failure to provide an effective onboarding process can be unfavorable to both the organization and the employee as neither one will have favorable outcomes. Weiss (2019) cautioned against sessions that are too long or too short and to be mindful of staff's anxiety about making sales.

According to Thomas (n.d.), organizations in the sales industry must understand that new employees cannot be expected to increase sales without learning proper strategies. Staff must not only review the employee guidelines but also understand their new environment. Organizations may want to also recognize the challenges of new employees who are vulnerable, have no relationships or connection to corporate culture, and need to become acclimated to a new environment (Watkins, 2019). Leaders or managers cannot assume their new sales staff will demonstrate immediate success. Instead, managers should dedicate time to teach new employees about the company's culture, specific tasks required in the role, and realistic expectations to reduce pressure on new staff to make sales (Thomas, n.d.).

Sales industry is another field that has many similarities with clinicians working within FFS organization in that their take home pay is a direct result of their sales. Based on the discussion presented about effective onboarding of sales associates, FFS leaders can follow the strategies employed and recommended for sales associates and not expect or assume that clinicians will be successful in the field without proper strategies or ongoing support. Although staff hold master's degrees and are licensed to provide counseling and therapy, their graduate

coursework and internships focus on developing clinical skills instead of business or financial acumen. As part of the socialization process, organizations may want to provide staff trainings to help them gain knowledge of running a business and skills to mitigate no shows and cancellations. It is critical leaders understand that providing clinicians with a case load without proper business training is ineffective and counterproductive. Recruiters and human resource personnel may also want to spend more time explaining the business structure of how an FFS works and set out expectation early to avoid disappointment and costly turnover.

Finally, socialization is an important process for the success of organizations. It includes recruiting, hiring, orientation, training, and networking (Tang et al., 2014). The absence of proper socialization results in decreased satisfaction and commitment leading to costly turnover rates for the organization. Organizations may not only suffer financially but also encounter hindered growth, diminished morale, and declining organizational culture that can potentially taint the reputation of that organization. Organizations that experience high turnover, due to poor conditions, can receive bad reviews and discourage other candidates from applying.

Job Satisfaction

Job satisfaction has been heavily researched and discussed across all types of organizations, and it is not a new defined concept. Aziri (2011) conducted a literature review on job satisfaction and its importance for organizations and listed several definitions by Hoppock, Vroom, and Spector. Hoppock, for example, defined the term as being a combination of a psychological, physiological, and environmental state affected by other extraneous factors (1935). Almost 30 years later, Vroom (1964) defined the term as the affective attitude of staff towards their job duties. Spector define the term as the way staff feel about their job and its various facets (1997). Aziri (2011) argued that job satisfaction is a complex term and can mean

many different things to different people. Many questions assessing job satisfaction focus on how employees view their work environment, supervisor, and coworkers. A few examples include: *"I like the people I work with; I sometimes feel my job is meaningless; I enjoy my coworkers"* (Spector, 1985). High job satisfaction is an antecedent for commitment. In Western culture, the construct of job satisfaction was studied throughout the Industrial Revolution and continued through the early 2000s; therefore, it was difficult to find current articles discussing this topic. As a result, relevant studies from different countries were explored. Regardless of where the study was conducted, job satisfaction has been found to be a precursor to employee turnover and retention (Barak et al., 2001; Bauer et al., 2007; Busatlic & Mujabasic, 2018; Calitz et al., 2014; De Gieter et al., 2011; Fleury et al., 2018; Yanchus et al., 2015). One primary reason job satisfaction has been studied across different organizations and different countries is to increase commitment, retain staff, and reduce turnover. The following subsections will discuss job satisfaction across different fields.

Mental Health Field

Herzberg's (1959) two-factor theory identifies motivator and hygiene factors that influence job satisfaction or dissatisfaction. Several studies have explored mental health clinicians' job satisfaction levels and found improved working conditions, nature of the job, support, autonomy, and pay elevated job satisfaction. For example, Willis-Shattuck et al. (2008) reviewed quantitative and qualitative articles that explored motivation factors influencing mental health workers' retention and found income, growth, work environment, training opportunities, recognition, and access to necessary tools predicted retention. The authors concluded although income contributed to satisfaction, other factors were stronger predictors of job satisfaction. Other studies have found pay being a predictor of job satisfaction (Pathman et al., 2002; Ren et

al., 2017). Schweitzer et al. (2013) conducted a self-reported study of 838 social workers working in a variety of settings including FFS and found compensation contributed to a social workers' job satisfaction more strongly than previous work suggested. Michaels and Spector's (1982) conducted a study with community mental health providers and found supervisory support and autonomy predicted job satisfaction.

Similarly, Lambert et al. (2012) surveyed 500 social workers working across a variety of settings including private, public, and behavioral sectors, and found social workers perceived autonomy and quality supervision as the strongest predictors of their satisfaction and commitment. Yanchus et al. (2015) conducted a study at the Veterans Health Affair with social workers, mental health nurses, psychiatrists, and psychologists and found autonomy as a predictor for job satisfaction and turnover whereas Fleury et al.'s (2018) study with mental health workers from Quebec, Canada, found a strong association between supervisor and team support and job satisfaction. Results of these studies showed commonalities in the variables that increased or decreased job satisfaction for mental health providers. These variables included pay, growth opportunities, autonomy, and various professional development training.

The research reviewed for this study highlighted mental health clinicians' needs and what employers can do to increase their satisfaction and commitment. A work environment with high support, good wages, autonomy, and proper teaming is likely to keep staff motivated. Motivated staff are more likely to feel satisfied in their positions.

Nursing Field

Nursing is another field that faces staff shortages, decreased job satisfaction, high turnover (Hunter, 2021; Perry et al., 2018), and burnout (Rudman & Gustavsson, 2011) similar to challenges of mental health clinicians in all industries. Existing literature reveals the

importance of organizational socialization and its relationship to increasing job satisfaction and performance (Karem et al., 2019; Kousar et al., 2018), low turnover (Asegid et al., 2014; Perry et al., 2018), and promotional opportunities (Asegid et al., 2014). These findings are not surprising as satisfied employees tend to perform their job duties in a manner that enhances service delivery. These positive feelings contribute to increased commitment and ultimately reduce costs associated with turnover. Other factors that have been found to influence nurses' job satisfaction include autonomy (Asegid et al., 2014; Michales & Spector, 1982; Yanchus et al., 2015), commitment (Karem et al., 2019) and supervisory support (McFadden et al., 2015). Atefi et al. (2014) conducted a study with 85 nurses from different departments and found working conditions, such as team cohesion, lack of rewards, benefits, opportunities for growth, and autonomy, influenced how nurses felt about their positions. These factors echo the challenges FFS clinicians face, though concerns with take-home pay are more unique to FFS clinicians.

Non-Mental Health Fields

Many factors impact staff's job satisfaction regardless of industry, including onboarding practices, benefits, pay, promotion, recognition, security, supervision, communication, fringe benefits, and the nature of the work (Spector, 1997). The early work of Churchill et al. (1974) highlighted the roles of sales associates in generating revenue and driving organizational growth. As a result, there has been research examining factors influencing sales associates' job satisfaction (Churchill et al., 1976) and the importance of skill building to increasing satisfaction, performance, and commitment (Pettijohn et al., 2007). Similar to sales associates who sell a product or provide a service, FFS mental health clinicians generate revenue by providing a service by way of treatment and wellness. Understanding factors influencing sales associates' job satisfaction may provide insight to FFS administrators who are limited in finding research about

FFS mental health clinicians' satisfaction factors. Although the two fields are unrelated and require different professional expertise and educational requirements, they are both responsible for generating revenue. The staff's compensation is tied to the number of products or services they provide. Churchill et al. (1974) identified pay, promotion, relationship with coworkers, customers, supervisors, and the nature of the work as factors that shape salespersons' job satisfaction. Additionally, Brown and Peterson (1993) identified role perception, task, and organizational variables as factors that increased satisfaction and commitment and decreased turnover rates (Donavan et al., 2004).

These are just a few of the fields that support Herzberg's (1959) two-factor theory of job satisfaction. There are commonalities across these disciplines of what employers need from their organizations. Across countries and different disciplines, support, pay, opportunities for personal growth, and promoting education or professional development were motivators, while poor working conditions, poor policies, and lack of growth were related to hygiene factors. The next section will focus on the construct of organizational commitment within different industries.

Organizational Commitment

Organizational commitment is another frequently studied construct. It is defined as the level of employees' engagement within an organization and whether they intend to leave or stay (Ghazzawi, 2008; Greenberg & Baron, 2011). Factors such as working conditions, potential pay, lack of upward mobility, poor supervision, and relationship with coworkers have been identified as influencers of both job satisfaction and commitment. Many researchers have found a relationship between job satisfaction and commitment (Ghazzawi, 2008; Ismail & Razak, 2016; Porter et al., 1974; Rafiee et al., 2015), but have disagreed regarding the direction of the relationship. Some have suggested job satisfaction is simply an antecedent to commitment

(Nagar, 2012; Suparjo, 2017), while others have found job satisfaction to directly predict commitment (Ćulibrk et al., 2018; Valaei & Rezaei, 2016), supporting one of the hypotheses of this study. In the contemporary labor market with rising concerns of staff retention, organizations cannot afford to ignore the importance of commitment for retention and turnover regardless of industry, including nonmental health fields (Carbery et al., 2003; Ćulibrk et al., 2018; Mulky, 2011; Wang & Huang, 2012).

Meyer and Allen (1991) developed the TCM and offered three different types of commitment: affective, normative, and continuance commitment. Affective commitment is employees' desire to stay in their organization. Normative commitment refers to employees who feel they should stay because it is the right thing to do. Lastly, continuance commitment implies employees stay because they are vested in the company and the cost to leave would be higher than the benefit of staying (Meyer & Allen, 1991). In this research study, organizational commitment will be operationalized using specific questions asking about affective commitment. Due to the limited literature about organizational commitment of FFS clinicians, the following subsections will address organizational commitment across different fields.

Mental Health Field

Lack of organizational commitment is a concern within health field (Baggerly & Osborne, 2006; Morris & Bloom, 2002; Porter, 1974; Weng et al., 2010; Yanchus et al., 2015). Literature reviewed within this study revealed that factors such as poor job satisfaction, burnout, poor support, high stress, and lack of commitment have all contributed to high turnover for social workers as well as other human service workers (Barak et al., 2001). In a large study with 1,786 social workers working in child welfare, mental health or other settings within the United States revealed that the best way to increase retention for organizations is to promote recognition,

wellness and a supportive organizational culture that increases both job satisfaction and wellness (Brown et al., 2019). Little is known about the commitment of FFS mental health clinicians and what factors impact their desire to stay. This study explores whether organizational socialization practices as well as job satisfaction play a role in FFS clinicians' affective commitment toward their organizations.

Nursing Field

The increased shortages and high turnover rates in the nursing field highlight the need for managers to focus on identifying ways to increase commitment. Organizational socialization and job satisfaction play important roles towards achieving commitment. For example, Erni (2019) conducted research on job satisfaction and nurses' commitment and found compensation to positively influence organizational commitment. Bartlett & Kang (2004) found other factors such as access and frequency of training and supervisory support to increase nurses' commitment level.

Non-Mental Health Field

Job satisfaction and organizational commitment work together in tandem and the higher the job satisfaction is, the greater the commitment. Ćulibrk et al. (2018) reported "organizational commitment can be thought of an extension of job satisfaction, as it deals with the positive attitude that an employee has, not toward her own job, but toward the organization" (p. 4). Developing positive attitude towards one job does not occur overnight, instead it occurs over a series of events during recruitment and onboarding as well as how well an employee is supported. Meyer and Allen (1991) postulated that staff begin to feel a sense of commitment when they feel they are part of the organization, and their values align with the organizations. This can be accomplished through feelings of receiving support, being provided clear

communication, having role clarity, and having feelings of being valued. Pettijohn et al. (2007) suggested that, when sales associates have positive perceptions about their skills, both their job satisfaction and organizational commitment increases.

Organizational Socialization, Job Satisfaction, and Commitment

The section discusses the concepts of organizational socialization, job satisfaction, and commitment and their relationship with one another in a variety of fields due to the lack of available literature specific to FFS mental health clinicians. With high turnover rates, understanding employees through the lens of Herzberg's (1959) theory and tending to staff needs may benefit organizations in increasing job satisfaction and commitment. The literature reviewed supports the positive relationship Van Mannen and Schein's socialization activities proposed to influence job satisfaction (Lacaze & Bauer, 2014) and commitment (Allen, 2006; Bauer & Erdogan, 2012; Carucci, 2018; Van Maanen & Schein, 1977). When new employees accept a position, they are often nervous and unsure of themselves (Van Maanen & Schein, 1959) and need reassurance, guidance, and support from the organization. Administrators invest time and resources during this crucial time. The return on this investment is by way of increasing retention. Turnover is costly and it has become a global issue. Offering the right socialization practices have supported increased satisfaction and commitment leading to retention.

Bauer et al. (2007), for example, conducted a meta-analysis with 70 studies and examined the role of socialization practices on new employee adjustment. They identified information seeking and organizational tactics as antecedents of new employee adjustment. Further, they identified role clarity, self-efficacy, and social acceptance as indicators of adjustment. Organizational tactics and information seeking positively affected performance, job satisfaction, intention to stay, and reduced turnover rates. Saks et al. (2007) conducted another meta-analysis

on organizational socialization and job satisfaction. They too found organizational socialization to positively affect job satisfaction, organizational commitment, and performance.

Studies focusing on socialization practices of nurses supported the positive relationship between socialization practices that increased job satisfaction and commitment (Karem et al., 2019; Kousar et al., 2018). A study conducted by Kurnat-Thoma et al. (2017) with hospital nurses found that offering improved onboarding practices reduced the turnover rate from 39.1% to 11.9% which supported the positive relationship between socialization practices and retention. Other studies with nurses focused on job satisfaction and found favorable correlations to their commitment (Hakami et al., 2020; Moradi et al., 2017), their experience (Laschinger, 2012), and performance (Karem et al., 2019). Studies also showed that offering activities that increased competence, knowledge about organizational policies, and a sense of integration increased retention (Tomeitto et al., 2015).

Similarly, studies about social workers working in a variety of settings supported the importance of providing support and promoting wellness by increasing job satisfaction and commitment to increase retention (Barak et al., 2001; Brown et al., 2019; Hansung & Lee, 2009). Harbert (2009), also studying social workers, discussed the process of recruitment and its relationship to retention. Lastly studies focusing on non-mental health fields provided similar results with engineers (Jahya et al., 2019), retail staff (Tang et al., 2014), banking (Abu-Doleh & Obeidat, 2018) and sales professions (Watkins, 2019; Mulky, 2011).

One of the critical elements for organizational success is to have satisfied staff. Satisfied staff tend to be more productive and committed (Bakotić, 2016; Ismail & Razak, 2016). Some researchers have suggested job satisfaction is an antecedent of organizational commitment (Yucel & Betkas, 2012), while others have argued job satisfaction directly predicts commitment

(Ćulibrk et al., 2018; Valaei & Rezaei, 2016). Findings from these studies revealed a positive relationship between job satisfaction and organizational commitment (Ćulibrk, 2018; Mulky, 2011) and it has shaped this study's research questions as well as the proposed hypotheses.

Summary

This chapter included reviews of literature about talent management, organizational socialization (i.e., task and organization), job satisfaction, and organizational (affective) commitment. It also included literature that illustrated the relationships between these variables. The review further examined the relationships between the constructs viewed through the lenses of Van Maanen and Schein's (1977) socialization theory, Herzberg's (1959) two-factor theory, and Meyer and Allen's (1991) TCM model. These theories provide support for the constructs as predictors of satisfaction and commitment. The literature highlighted the lack of specific socialization practices for FFS organizations as well as factors that influence their job satisfaction and commitment. It also guided the research questions and the study hypotheses. Additionally, it brought to light the similarities that individuals share regardless of their profession or discipline and whether they are salaried, or commission based. The review on factors influencing job satisfaction yielded similar results. Spector's (1985) research identifying pay, promotion, supervision, working conditions, benefits, policies, communication, and organizational conditions were the basis for many studies that researched the construct of job satisfaction. Finally, the literature included in this review revealed the absence of research on specific organizational practices and job satisfaction for FFS mental health clinicians; hence supporting the need for research specific to this employment environment. Table 4 illustrates the selected literature that helped shape the literature review.

Table 4

Selected Major Works That Influenced This Study

Author	Date	Research Field	Research Contributions Used in This Study
Van Mannen & Schein	1979	Organizational Socialization	Socialization tactics for new employees to increase satisfaction and commitment
Van Maanen &Schein	1977	Socialization	Theory of socialization
Jones	1986	Organizational Socialization	Socialization tactics. Individualized vs. institutionalized
Bauer	2010	Onboarding	Onboarding maximizes success
Bauer & Erdogan	2011	Organizational Socialization	Effective onboarding
Bauer & Erdogan	2012	Organizational Socialization	Outcome of effective socialization
Haueter et al	2009	Socialization	Newcomer socialization questionnaire. Instrument
Ashforth et al.	2007	Socialization	Tactics for teaching newcomers
Allen & Shanock	2013	Socialization	Socialization tactics of newcomers
Shufutinsky & Cox	2019	Onboarding	Onboarding millennials
Tuttle	2002	Socialization	Critiquing van Maanen & Schein tactics
Acevedo & Yancey	2011	Orientation	Western vs. Japanese model of Orientation
Abramson	1993	Orientation	Orientating social workers
Herzberg et al.	1961	Job Satisfaction	Two-factor hygiene-motivation theory of job satisfaction; hygiene and job dissatisfaction
Porter et. al.	1974	Job satisfaction commitment	The relationship between commitment satisfaction and turnover.
Churchill et al.	1974	Salespersons	Satisfaction surveys of sales personnel
Pettijohn et al.	2008	Salespersons	Satisfaction and intent to stay
Spector	1982	Job satisfaction	Impact of pay for performance
Rynes et al.	2004	Human resource	The importance of pay
Schweitzer et al.	2013	Satisfaction	Compensation and social work
Barak et al.	2001	Commitment retention	Retention factors for social workers
Meyer & Allen	1991	Commitment	Theory of commitment
Meyer et al.	1993	Commitment	Three component model of theory
Meyer & Allen	2004	Commitment	Survey, academic user guide
Michaels & Spector	1982	Turnover	Causes of turnover
Rubenstein et al	2017	Turnover	Voluntary turnover and discussion of antecedents
Seldon et al.	2015	Turnover	Voluntary turnover of human service organizations
Medical Director Institute	2017	Shortage	Shortage of providers
Wang & Hwang	2012	Commitment	Employee perception of commitment and job satisfaction.

CHAPTER 3: RESEARCH METHODOLOGY

Some outpatient mental health clinics (OMHC) compensate staff for a percentage of their billable hours instead of traditional salaries. If a client cancels or is a no show, staff do not get reimbursed for their time. This often results in poor job satisfaction and commitment and leads to high turnover. Current literature has demonstrated the importance of organizational socialization (i.e., task and socialization) for job satisfaction and commitment for mental health professionals in salaried positions, but there is limited research on socialization practices, job satisfaction, and affective commitment for FFS clinicians. This study identified common predictors of job satisfaction for FFS clinicians and analyzed the relationships between organizational socialization, job satisfaction, and affective commitment.

This chapter discusses the following topics: (a) significance of the study, research design, (b) research questions and hypotheses, (c) key variables, (d) participants and sampling, (e) procedures, (f) the IRB, (g) consent forms, (h) data collection methods, (i) measures, (j) data analysis, (k) potential threats to validity, and (l) limitations.

Significance of the Study

This study is significant as it will provide data to support socialization practices as a means for FFS administrators to improve and implement effective socialization practices to increase and enhance commitment. The study also identified common job satisfaction factors for FFS clinicians. Latif et al. (2013) posit that organizations can achieve success by increasing their staff's job satisfactions. Additionally, the results of this study can potentially create a paradigm shift by defying a long-standing stigma of poor wages, lack of autonomy, and burnout. Once leaders understand the relationships between socialization and commitment, they might be more open to examine their practices, adopt a new way of onboarding, and make necessary changes.

Research Design

This study was a non-experimental, cross-sectional, quantitative survey research design with a convenience sample. I explored relationships between organizational socialization practices (i.e., task and organization), job satisfaction, and commitment to FFS organizations. The quantitative nature of this research allowed me to measure staff's attitudes, feelings, and perceptions to generate statistically measurable numerical data. The selected instruments for this study assisted me in capturing staff's perceptions and attitudes towards their experiences. Based on study results, leaders may be able to examine their organizational socialization practices and seek opportunities for improvement. Additionally, leaders may be able to identify common factors that enhance job satisfaction and make necessary changes to increase both job satisfaction and organizational commitment. By understanding staff, FFS organizations may be successful in their retention efforts to meet the increased demands of individuals needing treatment and intervention.

Research Questions and Hypotheses

FFS mental health clinicians' job satisfaction and affective commitment require effective organizational socialization. This research identified opportunities to improve job satisfaction for FFS clinicians. It also examined the influence of organizational socialization on job satisfaction and affective commitment of FFS clinicians.

Research questions and associated hypotheses tested for this study were as follows:

Research Question 1: What are job satisfaction factors for mental health clinicians operating in FFS organizations?

Descriptive statistics were conducted to answer the first research question. There were no hypotheses associated with this research question.

Research Question 2: Does organizational socialization impact job satisfaction of FFS mental health clinicians?

This research question had two hypotheses associated with it.

H1: Organization socialization will have a positive relationship with job satisfaction for FFS mental health clinicians.

H2: Task socialization will have a positive relationship with job satisfaction for FFS mental health clinicians.

Research Question 3: Does organizational socialization impact affective commitment of FFS mental clinicians?

This research question had three hypotheses associated with it.

H3**:** Organization socialization will have a positive relationship with affective commitment of FFS mental health clinicians.

H4**:** Task socialization will have a positive relationship with affective commitment of FFS mental health clinicians.

H5**:** Organizational socialization (i.e., both organization and task) will have a positive relationship with affective commitment of FFS mental health clinicians.

Research Question 4: Does job satisfaction impact affective commitment of FFS clinicians? This research question had one hypothesis associated with it.

H6: Job satisfaction will have a positive relationship with affective commitment of FFS clinicians.

Participants and Sampling

The population of interest for this study included master's level licensed social workers, professional counselors, and marriage and family therapists working in FFS mental health clinics

in the Mid-Atlantic Region. The providers held advanced licensures such as licensed clinical social workers certifications (LCSW-C) or licensed clinical professional counselor (LCPC). Providers could also hold graduate-level licensure such as licensed master social worker (LMSW), licensed graduate professional counselor (LGPC), or licensed marriage and family therapist (LMFT). The differences between advanced and graduate-level licensures include hours of supervision and further examination depending on the discipline. The study sample included licensed mental health clinicians working in FFS OMHCs in Maryland.

Alumni from two universities with social work and counseling programs were invited to complete the survey. I did not have direct access to the email lists for either of the institutions, therefore, I sent the survey link to the faculty of each university. The faculty distributed the survey link via email to their graduate faculty contacts. Additionally, the survey link was posted on multiple clinicians' professional groups on social media. Through the listserv, the professional groups, and social media, the survey was shared with more than 2,500 clinicians in the Mid-Atlantic Region. Based on the survey distribution design, it was not possible to determine the number of recipients who received the email or viewed the postings. The surveys that were opened through SurveyMonkey were trackable.

Variables and Measures

This section describes the independent and dependent variables used in this study and their relationships with one another.

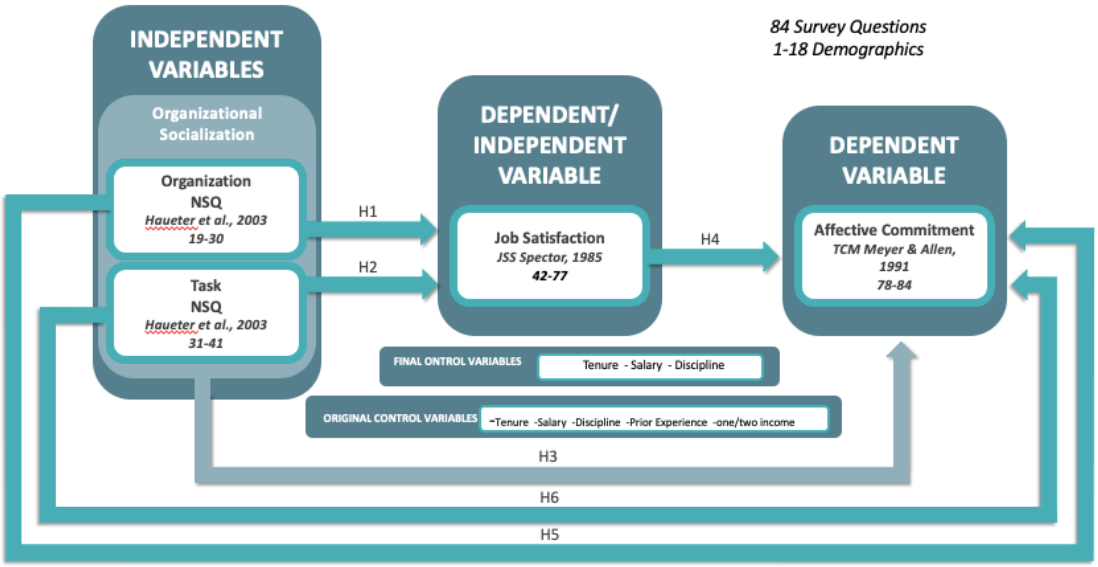
Study Variables

The variables for the study included organizational socialization, organization, the independent variables, job satisfaction as the dependent and independent variable and affective

commitment as the dependent variables. Figure 4 provides mapping of the hypotheses, the variables along with the measures that operationalized the study's variables.

Figure 4

Hypotheses with Variables and Measurement Model



The model is illustrating the hypothesized relationship between the study variables and measurement model. Organization and task socialization are exogenous variables, therefore the relationship between the two is not analyzed as they potentially overlap in meaning. Job satisfaction and affective commitment are endogenous variables. The paths to job satisfaction and commitment are unidirectional. The model also provides three validated instruments that have been widely used. NSQ will measure organizational socialization, JSS will identify common job satisfaction factors, and AC will measure staff' commitment to their organization. As shown in the illustration, there are two sets of control variables, the original five (tenure, salary, discipline, prior FFS experience, and one- or two- income household) variables that were dropped to three (tenure, salary, and discipline) due the sample size.

Measures

The survey had four different sections. The first section included demographic questions such as age, gender, race, income, whether participants lived in a one- or two-income household, licensure, tenure, county of employment, type of licensure, number of years in the field, and prior FFS experience. Additional questions asked participants about their organizational socialization experiences, the assignment of their first case, and whether time spent in onboarding was paid. There were two questions that addressed the COVID-19 and social injustice pandemics. Age, race, tenure, household income, and discipline were used as control variables. The second section of the survey used the Newcomer Socialization Questionnaire (NSQ) developed by Haueter et al., (2003). The third section included Job Satisfaction Survey (JSS) by Spector, (1985), and lastly, the fourth section of the survey used the three Component Model by Meyer & Allen (1991). Other than the demographic questions, the information was gathered through Likert-types surveys used by the developers. The NSQ questionnaire can be used for academic research free of charge. Allen provided permission to use the TCM survey (Appendix D), and the JSS could be used for academic research as long as the copyright was listed, and results shared on Spector's website. .

Organizational Socialization

The NSQ (Haueter et al., 2003) was used to measure knowledge staff attained during organizational socialization. This 35-item instrument includes three subscales: organization, group, and task socialization. This study focused both on task and organization domains. Due to the independent nature of an FFS position, group socialization was excluded from the survey. The organization subscale included 12 items, while the task socialization subscale included 11 items for a total of 23 items. A total score for all items was computed. The questionnaire used a

7-point summated Likert scale. Possible responses ranged from1 (*strongly disagree*) to 7 (*strongly agree*). In previous research (Spagnoli et al., 2018), Cronbach's alpha for OS was .86 and .87 for TS suggesting high interna consistency. Cronbach's alpha within this study for TS was .93 and .91 for OS. When using the questionnaire for this study, I used specific vocabulary that related to the use of technology within the field. For example, an original question is *In the course of performing my job, I understand how to complete necessary forms/paperwork (e.g., time sheets, expense reports, order forms, computer access forms*). For the survey, I added EMRs (electronic medical records) as one of the examples of *necessary forms/paperwork.*

The NSQ was chosen for this study as it addressed limitations of previous measures that focused only on providing socialization tactics but did not measure whether staff learned the skills (Haueter et al., 2003; Spagnoli et al., 2018). Haueter et al. (2003) argued socialization must include not just gaining organizational information but also learning the values, leadership style, and goals of the organization. The questions within these two domains measured whether staff learned information about their organizations such as, *I know the history of this organization (e.g., when and who founded the company, original products/services, how the organization survived tough times and specific tasks needed to perform their job duties.* In contrast, the task domain focused on specific job functions such as, *I know the responsibilities, tasks and projects for which I was hired.*

Job Satisfaction

The JSS (Spector, 1985) is a 36-item scale with nine subscales used for this study to assess common factors associated with job satisfaction of participants. This instrument assesses employee attitudes toward their job. The nine subscales are pay, promotion, supervision, fringe benefits, contingent rewards (i.e., performance-based rewards), operating procedures (i.e.,

required rules and procedures), coworkers, nature of work, and communication. Each subscale was assessed with four questions on a 6-point Likert scale with response options ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). An example item from the pay subscale was, *I feel I am being paid a fair amount for the work I do*. Another example item from the communication subscale was, *Communication seems good within the organization*. Nineteen of the 36 items are negatively worded and reversed coded. Cronbach's alpha from prior work ranged from .60 to .91 (Spector, 1985). The scale has been widely used consistently tested for both reliability and validity (Astrauskaite et al., 2011; Barak et al., 2001; Batura et al., 2016; Gholami et al., 2012; Van Saane et al., 2003). Within this study, Cronbach's alpha ranged between .75 and .90. The JSS was selected for this study as the instrument was developed to capture the attitudes of individuals working in the human service industry and in different types of organizations (Spector, 1985).

Organizational Commitment

The TCM commitment survey (Meyer & Allen, 1990, 1991) is an 18-item survey with three subscales that was used for this study to measure commitment. The instrument assesses the three forms of employee commitment to an organization: affective commitment (AC), continuance commitment (CC), and normative commitment (NC). Each of the three subscales can be scored independently. There are two versions of the survey. The original survey included 24 questions, while the revised, shortened version includes 18 questions. The authors explained the similarity in both versions and the choice to use either one depended on the desired length (Meyer & Allen, 2004). According to Meyer and Allen, the greatest difference between the two versions lies in the normative commitment subscale (i.e., staff stay because they feel obligated). The revised version focused more on feelings of obligation without giving any reasons. I selected

the shortened version to reduce the number of total survey questions. Additionally, I only focused on the affective commitment subscale to measure staffs' desire to stay in their organization. The academic version was approved for use in this research. Meyer and Allen's (1991) TCM model has become a tenet of organizational commitment. Some questions were reverse coded, so that higher scores were associated with higher levels of commitment.

The instrument uses a 7-point Likert-type scale with response options ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). An example item from the affective commitment subscale is *I would be very happy to spend the rest of my career with this organization*. The instrument has a total of seven questions. According to Meyer and Allen (1991), internal consistency for affective commitment was .87. Other studies (De Gieter et al., 2011; Fritsche & Fortunato, 2016) with reliability scores of .85 and .81 respectively.

Procedures

The survey was in English and emphasized the voluntary nature of participation and participants' ability to stop any time. Participants were entered into a drawing to win a $100 Amazon gift card for their participation. Individuals who wanted to enter the optional drawing sent their contact information to be entered to the drawing. After Data were collected at one point in time using a convenience sample of licensed mental health clinicians in the State of Maryland. To estimate the sample size of the target population, I explored the U.S. Bureau of Labor Statistics (BLS, 2019) website and used the occupational employment query system. I chose multiple occupations in Maryland. Seven categories matched the target sample. The following categories were selected: a) clinical and school counseling; b) marriage and family therapists; 3) substance abuse, behavioral disorder, and mental health counselors; 4) all other

counselors; 5) mental health and substance abuse social workers; and 6) all other social workers. This totaled 8,890 professionals, although it was unclear how many of those clinicians worked in FFS mental health services based on the query. Between commitments from institutions and social media posts, the survey was shared with a minimum of 2,500 clinicians. The survey was specific to clinicians within FFS. To estimate the minimum sample size, I used the G*Power statistical calculator with five predictors (Tenure, One/two income, Discipline, Prior experience, Salary) at 80% power and a .05 alpha level and determined I would need 91 participants to detect a small effect size of .15 (Faul et al., 2009).

Institutional Review Board Approval and Informed Consent

The study was approved by Hood College Institutional Review Board (IRB) on February 9, 2021. The IRB application and the approval letter (Appendix A) are included. Participants completed online consent forms. The consent forms provided a detailed description of the study's purpose and procedures. To increase participation, participants were offered an opportunity to win a $100 Amazon gift card in a drawing. Participant consent was confirmed once they acknowledged the voluntary nature of the study, agreed they possessed the required licenses, and read and provided electronic consent. The copy of the introduction letter along with the consent form (Appendix B), and the survey questions (Appendix C) were included. Ethical practices were followed to ensure confidentiality and respect for persons, and the absence of risk was explained (U.S. Department of Health and Human Welfare, 1979).

Pilot Study

To ensure accuracy and efficiency, I conducted a small pilot study in the FFS organization in which I am employed. Before I conducted the pilot study, I received permissions from both organization's owners (Appendix D). To avoid potential conflict due to my position in

the company, I sent the survey to site directors in five different counties who I did not directly supervise. The purpose of the pilot was to assess the length of time it took to compete the survey, the clarity of the questions, and whether there was a need to make any revisions. The professionals who took the survey reported they finished it in less than 15 minutes and that the questions were clear, so no revisions were made.

Data Collection

After the pilot was completed, I uploaded the survey link, the welcome letter, and the informed consent form (Appendix B) on Facebook, LinkedIn, and three professional groups (Mental Health Practitioners of Baltimore/Washington Metro, Business of Purposeful Practices, and Hood College Social Work Program). The same information was distributed to two higher education institutions in the Mid-Atlantic region offering counseling and social work programs. The representatives agreed to share my research with their graduate alumnae and provided email confirmation (Appendix D). I reposted the links every other day alternating between Facebook, LinkedIn, and the different social work and counseling groups. A total of 104 responses were collected.

There were four survey sections with a total of 84 questions. Specifically, there were nine demographic questions, four exploratory questions focusing on specific socialization tasks, two questions about the pandemics, and two optional questions. Additionally, 23 questions focused on socialization practices, 36 questions focused on job satisfaction, and 7 questions focused on commitment. The instruments (NSQ, JSS, and AC) I used to measure organizational socialization, job satisfaction and commitment instruments were vetted, and validated surveys used to measure the constructs of this study.

The survey was conducted through SurveyMonkey. I followed all ethical procedures to protect participant confidentiality. No personal or organizational information was requested. Data were stored electronically on a protected device using Microsoft OneDrive cloud storage with only my login credentials. To ensure responses remained anonymous, I selected the turn off feature for the anonymous response and IP address in SurveyMonkey. After participants completed the survey, they were given the option to send their email address (only accessible to the researcher) to be entered into the gift card drawing and deleted afterwards. The forced response option was used on all 84 empirical and control questions. Other questions offered the choice, *prefer not to respond*.

Data Analysis

IBM SPSS version 27 was used for statistical analyses. First, I ran descriptive statistics to provide demographic data including age, gender, race, tenure, household income, income level, experience in the field, and specific socialization practices. In addition, descriptive statistics were provided and analyzed to identify factors indicative of job satisfaction using the JSS questionnaire. This included pay, promotion, supervision, opportunities for advancement, benefits, working conditions, nature of work, coworkers, communication, and rewards. Next, I ran inferential statistics in SPSS using a path analysis model to examine relationships among the variables. The study examined the following relationships: Task socialization and job satisfaction; organization socialization and job satisfaction; job satisfaction and affective commitment; task socialization and affective commitment; organization socialization and affective commitment, and, lastly, organizational socialization and affective commitment. This model is similar to a regression model as both are based on linear statistical model traditions (Streiner, 2005). Table 5 illustrates the survey questions that addressed each research question

and Table 6 illustrates the instruments used and statistical tests conducted for each study variable.

Table 5

Research Questions, Survey Tools, and Variables

Research Questions	Questionnaire	Construct
1. What are job satisfaction factors for FFS clinicians?	JSS (Spector, 1985), Nos. 42-77	Job satisfaction
2. Does organizational socialization (organization and task) impact job satisfaction?	NSQ (Haueter et al., 2003) OS. Nos.19-30 TS Nos. 31-41	Organization socialization (organization and task) Job satisfaction
3. Does organizational socialization impact affective commitment for FFS clinicians?	NSQ (Haueter et al.,2003) OS &TS No's.19-41	Organizational socialization Affective commitment
4. Does job satisfaction impact affective commitment for FFS clinicians	TCM (Meyer & Allen, 1993), Nos. 78-84	Job satisfaction Affective commitment

Table 6

Study Variables, Measures, and Statistical Tests

Variable	Instrument	Data	Units of Measure	Statistical Tests
Demographic	Developed by researcher	Age, gender, tenure, race, licensure, prior FFS, income, paid socialization, length of socialization, county of employment, one or two household incomes	Nominal, Ordinal Categorical	Descriptive
Organizational (OS, TS)	NSQ (Haueter et al., 2003)	7-point Likert-type scale	Scale	Descriptive, path analysis
Job satisfaction	JSS (Spector, 1985)	6-point Likert-type scale	Scale	Descriptive, path analysis
Organizational Commitment	TCM (Meyer & Allen, 1991)	7-point Likert-type scale	Scale	Descriptive, path analysis

Reliability, Validity, and Limitations

Reliability

Every research can have challenges impacting its reliability. Within the study, sampling bias, recall and social desirability bias were addressed along with measures taken to avoid reliability challenges.

Sampling bias stems when the sample is not a true representation of the population of interest. The survey was shared with alum of two universities and social media platforms therefore excluded clinicians who attended different universities or were not on social media. Social desirability bias as clinicians may have answered what was socially acceptable instead of sharing their true feelings. Another bias can be recall bias. The survey asked about prior organizational socialization practices and participants may not remember the true experiences of their socialization practices and either exaggerate or minimize their experiences. Lastly, non-response bias due to the events of 2020 and the time constraints that clinicians were under may have resulted to abandoning the survey or not completing it. According to Hagan (2014), when instruments have shown a good-test-retest reliability and internal consistency, they can be considered reliable and can be used in other studies.

Validity

As with any research, my study had validity threats. The study was a cross-sectional and non-experimental design; thus, causality cannot be claimed. By using reliable scales and having appropriate sample size, internal validity issues were minimized (Maruyama & Ryan, 2014). Additionally, I used control variable to control for spuriousness. According to Nunnally (1967), a reliable instrument must meet the Cronbach's alpha threshold of .70 or above. Within this study, the Cronbach's alpha for affective commitment was .92, organization socialization was .91, and

task socialization was .93. The total score for job satisfaction was .96, and the different facets for job satisfaction varied between .75 to. 90.

External validity is also limited as no generalizations can be made due to the sample size (81) and sampling method. Construct validity issues can merge when operational definitions do not align with constructs and when using non reliable instruments (Maruyama & Ryan, 2014). The constructs within this study were operationalized by individual questions using reliable and previously validated instruments. The Cronbach's alphas in the study instruments ranged between .91 to .96, improving the construct validity.

Conclusion validity within the study is considered adequate, as the sample size was appropriate based on the analysis of the desired statistical power. Additionally, using the right instruments and having control variables to eliminate alternative explanations of spuriousness minimized issues with conclusion validity

Convergent validity is the degree of similarity between one instrument and another to ensure they measure the same construct. The acceptable score for convergent validity is a minimum of .50. The JSS has demonstrated high convergent validity through comparisons to several other job satisfaction surveys, including the Job Descriptive Index (JDI) and Minnesota Satisfaction Survey (MSQ). The NSQ has been compared to the Socialization Scale (Chao et al., 2012), and the TCM has been compared to a questionnaire Porter et al. (1974) developed—the Organizational Commitment Questionnaire (OCQ) (as cited in Cohen, 1999).

Limitations

Like all studies, thus study had several limitations that include the small sample size. Although the sample was adequate for the number of variables, a larger sample would have enhanced the validity of this study and, because of this, results cannot be generalized. Second,

recruitment of participants was through two universities and professional groups on various social media platforms and only alums or clinicians who were active on social media had access to the survey. Therefore, the results of the survey may have not captured the opinions and experiences of all FFS clinicians. Third, the study was a quantitative, cross-sectional survey and did not capture change over time in perceived levels of satisfaction and commitment and excluded current environmental factors such as COVID-19 and racial injustice. The quantitative nature of the study limited the ability to add contextual meaning to the study. Sampling bias is also a limitation as some participants may have felt uncomfortable and answered the questions based on socially desirable responses. Some staff were reported being at their organization over 2 years and they may have not remembered events or experiences and omitted important details. A third limitation was the toll the two pandemics took on clinicians' time and wellbeing. Although the survey was of a reasonable length, asking clinicians for an extra 15 minutes in their day may have added undue burden that forced them to abandon the survey or not complete it altogether. Another limitation was the inability to generalize the results.

Summary

The purpose of this chapter was to address methodology used for this study. The chapter presented information on the design of the study, purpose, and sampling. The chapter also included the data analysis plan, validity and reliability issues, and limitations. Chapter 4 will present the study findings and discuss emerging themes. Chapter 5 offers discussions, recommendations, limitation and implication for future research.

Table 7

Methodology and Chapter 3 Summary

Element	Summary
Research Design	Quantitative cross-sectional study
Participants	Social workers and counselors (LMSW, LGPC, LCSW-C, LCPS, LMFT)
Procedure	The survey was in English and was voluntary
Pilot Study	No revisions were made
Data Collection	Data collected anonymously through SurveyMonkey
Reliability	social desirability; sampling bias; non-response bias and recall bias.
Validity	Internal, external, construct, conclusion and convergent validity.
Limitations	• Convenient sample • Lack of generalizability • Sampling, recall, social desirability bias • Impact of pandemic impacting sample size

CHAPTER 4: RESULTS AND ANALYSIS

This study examined the relationships between organizational socialization (organization and task), job satisfaction and affective commitment of mental health clinicians working within fee-for-service (FFS) clinics. Existing research demonstrated that organizational socialization practices (onboarding) can lead to both job satisfaction and affective commitment. As part of the study, a survey conducted with mental health (MH) clinicians (social workers and professional counselors) possessing different licensure levels examined how task and organization socialization influence both job satisfaction and commitment.

This chapter offers the analyses and results of this study. It starts by summarizing the methodology, the attributes of the participants, analyses used, and then a discussion of the variables. The next section discusses the research questions along with the hypotheses and analyses of the relationships between the variables. It will then offer the study results as related to the following research questions:

Research Question 1: What are job satisfaction factors for mental health clinicians operating in FFS organizations?

Descriptive statistics were conducted to answer the first research question. There were no hypotheses associated with this research question.

Research Question 2: Does organizational socialization impact job satisfaction of FFS mental health clinicians?

This research question had two hypotheses associated with it.

H1: Organization socialization will have a positive relationship with job satisfaction for FFS mental health clinicians.

H2: Task socialization will have a positive relationship with job satisfaction for FFS mental health clinicians.

Research Question 3: Does organizational socialization impact affective commitment of FFS mental clinicians?

This research question had three hypotheses associated with it.

H3**:** Organization socialization will have a positive relationship with affective commitment of FFS mental health clinicians.

H4**:** Task socialization will have a positive relationship with affective commitment of FFS mental health clinicians.

H5**:** Organizational socialization (i.e., both organization and task) will have a positive relationship with affective commitment of FFS mental health clinicians.

Research Question 4: Does job satisfaction impact affective commitment of FFS clinicians? This research question had one hypothesis associated with it.

H6: Job satisfaction will have a positive relationship with affective commitment of FFS clinicians.

Summary of Methodology

This research study was a non-experimental, cross-sectional survey using a convenience sample. The survey identified common job satisfaction factors and examined relationships between the independent and dependent variables. Data were collected anonymously from clinicians working for OMHCs. The 84 survey questions were drawn from vetted instruments (NSQ, JS AC) and demographic questions. Foundational instruments are included in Appendix C.

Data Preparation and Case Validation

Once data collection was completed, responses were downloaded to SPSS version 27. I reviewed the surveys individually to determine if responses were sufficiently completed. The individual inspection revealed 23 out of the 104 participants did not fully complete the survey and were all removed for the following reasons: six did not indicate what type of license they possessed; five did not indicate their salary; one person did not include their age; and 11 did not answer at least one of the four main constructs (organizational socialization, job satisfaction, and affective commitment) leaving a total final number of 81 fully completed surveys.

Study Variables

The study's variables included organization and task socialization, job satisfaction and affective commitment; salary, tenure, and licensure were used as controls. Table 8 lists the study variables, measures, and statistical tests.

Table 8

Study Variables, Measures, and Statistical Tests

Variable Name	Variable Type	Level of Measure	SPSS Description	Survey Questions
Organization	Independent	Scale	Org	Nos. 19-30
Socialization	Independent	Scale	Task	Nos. 31-41
Task Socialization	Independent	Scale	Jobsat.	Nos. 42-77
Job Satisfaction	Dependent	Scale	Affect	Nos. 78-84
Affective Commitment	Dependent	Scale	Jobsat.	Nos. 42-77
Household Income	Control	Scale	Salary	No. 6
Discipline	Control	Scale	License	No. 4
Prior Experience	Control	Scale	Priorexp	No. 7
Discipline	Control	Scale	Tenprof	No. 9

After preparing the data, mean scores were calculated for each of the constructs. These included mean scores for task socialization (11-items measured on the NSQ task- subscale), organization socialization (12-items on the NSQ-Organization-subscale), affective commitment (6-items on the shortened TCM affective subscale) and job satisfaction (36-items measured on the JSS survey).

Before calculating the mean scores for affective commitment and job satisfaction, I reverse scored for negatively worded questions. For affective commitment items 3, 4, and 5, (*I do not feel a strong sense of "belonging" to my organization*; *I do not feel "emotionally attached to this organization*; *I do not feel like "part of the family" at my organization*) were reverse scored so that 1=7, 2=6, 3=5, 4=4, 5=3, 6=2, 7=1. For job satisfaction, I reverse scored 19 items (2, 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24, 26, 28, 30, 32, 34, 36) so that 1=6, 2=5, 3=4,4=3, 5=2, 6=1. After calculating the mean scores for the 36 items, I calculated the mean score for the 9 facets (pay, promotion, supervision, fringe benefits, contingent rewards, operating conditions, coworkers, nature of work, communication).

Figure 5 presents mapping of the relationships between the variables within the study. It also provides the associations between the variables and the analyzed hypotheses. Table 9 provides all six hypotheses and the primary variables associated with each hypothesis.

Figure 5

Mapping of the Hypotheses

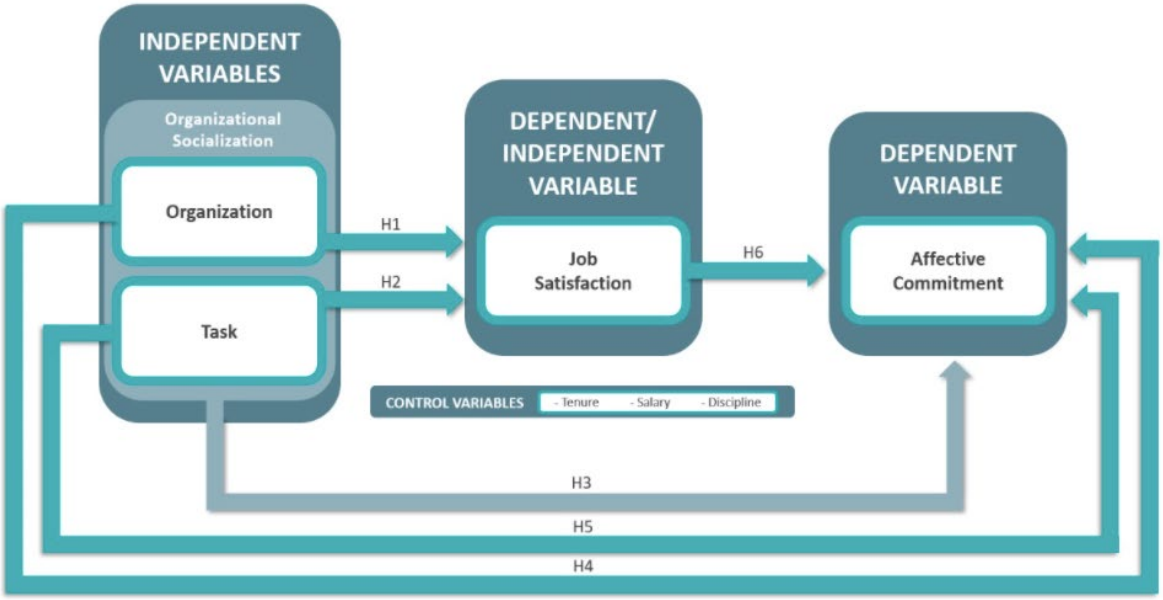


Table 9

Hypotheses of the Study

Hypotheses	Primary variables
H1: Organization socialization (OS) is positively related to job satisfaction (JS) of FFS MH clinicians	OS, JS
H2: Task socialization (TS) is positively related to job satisfaction of FFS MH clinicians.	TS, JS
H3: Organizational socialization is positively related to affective	OS, AC
H4: OS is positively related to AC of FFS MH clinicians	OS AC
H:5 TS is positively related to AC of FFS MH clinicians	TS, AC
H:6 JS is positively related to AC of FFS MH clinicians	JS, AC

Characteristics of Participants

Participants of the study were master's level counselors and social worker who carried different licensure levels (LMSW, LGPC, LCSW-C, LGPC, and LMFT). They were also employed within FFS outpatient mental health clinics. Participants were invited through emails

sent by two universities within the Mid-Atlantic region to alums, as well as Facebook, LinkedIn, and members of my professional groups listed on Facebook and LinkedIn. I was not provided direct access to the email addresses. A total of 104 participants completed the survey but 23 were removed due to missing information leaving 81 valid cases.

Variable Descriptive Statistics

This quantitative, non-experimental study surveyed FFS MH clinicians within Maryland and drew from 81 completed surveys and demographic data regarding clinicians' age, race, gender, ethnicity, tenure, income, and discipline. Descriptive statistics were computed for each variable. Continuous variables were age, organization socialization, task socialization, job satisfaction and affective commitment. The mean, standard deviation, and range for all continuous variables were calculated. In instances of more than one measure, I ran the tests and provided the Cronbach's alpha. Categorial variables were race, gender, tenure, salary, and licensure for which I provided the frequency (%) and count (N). One question focused on asked about their Questions were also asked about how organizations responded to both Covid-19 and the racial injustice. The 81 participants were over the minimum sample size of 77 required to run linear regression with 3 predictors, an *a priori* alpha level of .05, power level of .80, and minimum effect size of .15, as calculated in G*Power v. 3.1.9.3 (Faul et al., 2009). After running all the descriptive statistics, I ran t-tests, linear regressions, and HLRs to look for relationships and to see how the independent variables predicted the dependent variables.

Demographics

Demographic data for 81 out of 104 respondents are discussed in the following subsections. Because 23 out of the 104 respondents did not fully complete the survey, as a result they were removed from the analysis leaving 81 valid cases.

Age/ Gender/Race/Ethnicity

There were 81 participants in this study. The median age of the participants was 39.4 years with a range of 23-71, and a SD of 11.23. Female participants comprised 91.4% (76) of the sample. Of the 81participants, 80.2% (65) were White/Caucasian, 4.9% (4) were Black/African American, 3.7% (3) were Asian/Asian Americans, and 3.7% (3) identified as two or more races. These numbers were reflective of a 2020 survey in which the number of White female clinicians ranged between 68.2% to 89.8% (BLS, 2020). Regarding Black clinicians, the study's sample was not representative of the target clinician population that ranged between 9.2% to 26.8%. Considering the small sample size of this study, three clinicians (3.7%) identified as Asians or Asian Americans which was higher than the target population that ranged between .6% to 3.7%

Salary

The salaries of the participants ranged between $25,000 to over $150,000. Within this study, 22.2% of the respondents reported a salary between $25,000 to $49,000. 4.7% reported $50,000 to $64,999, 19.8% ranged between $75,000 to $99,000 and 6.2% reported a range of $100,000 to $150,000, and, lastly, 4.9% reported income over $150,000.

Licensure/Discipline

The participants were asked about their discipline and licensure levels. Of the participants, 46.9% were social workers and held LCSW-C licensures. LMSWs followed at 18 (22.9%), and the remainder 17 (21%) of the participants were LCPCs.

Tenure in Profession

Participants were asked about the length in their profession and 18(22.2%) reported being in the field for less than two years, while 15 (18.5%) had been practicing for 3-5 years, 26 (32.1%) between 6-10 years, 12(14.8) reported a range of 11-15 years, 10 (12.3) reported being in the profession for 16 and more years.

Tenure in Organization

Participants were asked about the length of their employment with their current organization and 37 (45.7%) had been employed for two years or less, while 26 (32.1%) were employed between 3 to 5 years, 14 (17.3%) participants were employed between 6 to 10 years, 3 (3.7%) individuals were employed between 11-15 years, and 1.2% (1) had 16 or more years.

Prior Experience, One/Two Household Income

Of the 81participants, 33% (27) reported having prior experience with the FFS model, while 66% (54) reported having none. Of the participants, 22 (27%) reported a one-income household, and 58 (71.6%) reported two-income households. One respondent (1.2%) did not answer this item. Table 10 lists the statistics for the categorical variables.

Table 10

Descriptive Statistics for Categorical Variables

Variable	N	%
Gender		
Male	7	8.6
Female	74	91.4
Total	81	100
Race		
White or Caucasian	65	80.2
Black or African American	4	4.9
Hispanic or Latino	6	7.4
Asian or Asian American	3	3.7

Variable	N	%
Two or more races	3	3.7
Total	81	100
Salary		
Between $25,000 and $49,999	18	22.2
Between $50,000 and $64,999	20	24.7
Between $65,000 and $74,999	18	22.2
Between $75,000 and $99,999	16	19.8
Between $100,000 and $150,000	5	6.2
Over $150,000	4	4.9
Total	81	100
License/Discipline		
Licensed Master Social Worker (LMSW)	18	22.2
Licensed Clinical Social Worker (LCSW-C)	38	46.9
Licensed Graduate Professional Counselor (LGPC)	8	9.9
Licensed Clinical Professional Counselor (LCPC)	17	21.0
Total	81	100
Tenure in Profession		
2 years or less		
3-5 years		
6-10 years		
11-15 years		
16 or more		
Total		
Tenure in Organization		
2 years or less	37	45.7
3 -5 years	26	32.1
6-10 years	14	17.3
11-15 years	3	3.7
16 or more years	1	1.2
Total	81	100
One/two income Household		
One income household	22	27
Two income household	58	71.6

Variable	N	%
Prefer not to answer	1	1.2
Total	81	100
Prior experience with FFS		
Yes-prior experience	27	33.3
No- no prior experience	54	66.7
Total	81	100

Summary of Demographics

The participants of the study were licensed professionals possessing various licensures (LMSW, LGPC, LCSW-C. LGPC, and LMFT) and working within FFS mental health clinics. Questions were asked about their age, race, gender income, salary, tenure, and level of their licensure. Demographic information revealed that most participants were White females with incomes ranging between $25,000 to over $150,000 with a median age of 39.4 years. Most had no prior experience within the FFS field, were employed for 2 years or less, came from two income households, and held LCSW-Cs.

Organizational Socialization Practices

Participants were asked about their organizational socialization experiences, the length of the training, and whether they were compensated for their time. Additionally, they were asked about the timing of their first case assignment. Table 11 provides the breakdown of their answers.

Table 11

Organizational Socialization Experiences

Variable	N	%
When you were hired, did you receive onboarding beyond orientation?		
Yes	38	46.9

Variable	N	%
No	43	53.1
Total	81	100
How long was your onboarding experience?		
1-7 days	62	76.5
8-15 days	5	6.2
16-22 days	0	0
23-30 days	2	2.5
Over a month	2	2.5
Other	10	12.3
Prefer not to answer	0	0
Total	81	100
Were you compensated for your onboarding?		
Yes- Paid	45	56
No- Unpaid	35	43
Prefer not to answer	1	1
Total	81	100
First Case Assignment		
1-7 days	53	65.4
8-15 days	15	18.5
16-22 days	3	3.7
23-30 days	3	3.7
Over 31 days	6	7.4
Prefer not to answer	1	1.2
Total	81	100

Length of Organizational Socialization (onboarding)Practices

Of the 81 participants, 46.9% (38) reported receiving onboarding practices beyond orientation and 53.1% reported receiving orientation. As far as their prior experiences, 33.3% (27) had prior FFS experience versus 66.7% (54) who had no prior experience in a similar clinic.

Tenure in Profession

Participants of the study had been in the field of mental health for a range of 2 to16 years. Of the participants, 22% (18) had been in their current profession 2 years or less, 18% (15) had 3-5 years, 32.1% (26) reported a range of 6-10 years, 14.8% (12) had been in the profession between 11-15 years, and, lastly, 12.3% reported over 16 years in the profession.

Case Assignment

Participants were asked about the timing of the assignment of their first case upon being hired and 65.4% (53) reported receiving their first case between 1-7 days, 18.5% (15) between 8-15 days, 3.7% (3) between 16-22 days, and 23-30 days, and, lastly, 6 received their first case after 31 days. One person declined answering the question.

Types of Organizational Socialization (Onboarding) Experiences

Participants were asked about their specific organizational socialization (onboarding) experiences. Table 12 lists the different practices. Of the 81 participants 17.5% (14) reported receiving HR orientation (benefits, company policies, mission, and vision), 18.5% (15) were introduced to key individuals and learned the history of the company, in addition to their orientation, 18.5(%) reported receiving orientation, introductions, and learned about the company history. 11.1% (9) reported learning about the company's culture in addition to orientation and introductions. Of the 81 participants, 34.6% (28) reported receiving orientation, introductions, learning about history and culture, as well as time management, where to seek help, and specific

strategies for success. Finally, 17.2% (14) checked *None of the above,* and 1.2% (1) checked *Preferred not to answer.* Table 12 displays the responses to the onboarding experiences item.

Table 12

Specific Onboarding Experiences

Variable	N	%
What type of onboarding experience did you receive?		
HR orientation (benefits, company policies, mission and vision).	14	17.5
HR orientation, introduction to key individuals, history of the company.	15	18.5
HR orientation, introductions to key individuals, history and company culture	9	11.1
HR orientation, introduction to key individuals, history, company culture, time management, seek help, and strategies for success	28	34.6
None of the above	14	17.3
Prefer not to answer	1	1.2
Total	81	100

Covid-19 Pandemic

Participants were asked about their experiences about the pandemics of Covid-19 and the racial injustice towards the black community. Out of the 81 participants, 45.5% (37) responded reported satisfaction-Yes, and 29.6% (24) responded with a No. 3.7% (3) selected prefer not to answer about Covid-19 pandemic. *Table 13 displays the participants' response.*

Table 13

Covid-19 Pandemic

Variable	N	%
Did your organization address the Covid-19 pandemic to your satisfaction?		

Variable	N	%
Yes	54	66.7
No	24	29.6
Prefer not to answer	3	3.7
Total	81	100

Racial Injustice Pandemic

In regard to the racial injustice 45.7% (37) reported that their organization addressed the topic, while 50.6% (41) responded with ***no***, and 3.7% (3) chose *prefer not to answer*. Tables 14 and 15 provides the distribution of their answers**.**

Table 14

Racial Injustice

Variable	N	%
Did your organization address racial injustice to your satisfaction?		
Yes	14	17.5
No	15	18.5
Prefer not to answer	9	11.1
Total	81	100

Geographic Location of Participants

The question about their location was optional. The participants were from 10 different counties within Maryland. Of the participants, 11.1% (9) were from Baltimore. Of these nine, two selected as having two or more races, the rest identified as White. Baltimore City had 4.9% (4) participants of which two reported being white, and two reported having two or more races. Frederick county had 33.3% (27) participants. Of the 27 clinicians, one was Asian American, and one was Hispanic/Latino, the rest reported being White. Montgomery county had 27.2% (22) of the participants. Of the 22, four were Hispanic, two were Black, and the remaining clinicians were White. Prince Georges County had 7.4% (6) participants and they were divided among four races: three were White, one was Asian American, one was Black, and one was Hispanic/Latino. The remainder of the respondents were all White and were from Washington, Harford, Howard, Carroll, and Charles counties. Table 15 provides the breakdown of the county of their employment.

Table 15

Optional: Geographic Location

Variable	N	%
What county are you employed in?		
Baltimore	9	11.1
Baltimore City	4	4.9
Carroll	4	4.9
Charles	1	1.2
Frederick	27	33.3
Hartford	2	2.5
Howard	1	1.2
Montgomery	22	27.2
Prince George	6	7.4
Washington	5	6.2
Total	81	100

Optional/Additional Comments

Of the 81 participants, six completed question 18 and left comments**.** Table 16 lists the comments.

Table 16

Optional/Additional Comments

Question 18	Comments
Additional Comments	"The onboarding happened when I started as an Intern. Many therapists who were hired to start as employees FFS, did not receive as extensive onboarding as the interns did. Also, we were paid to do online trainings that were mandated by the agency, but we did not get paid if we were not in a training session, just setting up our office".
	"I am in a second career where I still work full time in addition to part time work as an LGPC".
	"Practice has been supportive beyond expectations."
	"Fee-for-service is a problem because of having no leave time, especially with COVID 19".
	"My agency has increased caseloads while threatening to modify pay schedule while also withholding the Medicaid fee increases and ending contributions to our retirement. My onboarding experience was a couple of hours in Towson where several of the employees I was scheduled to meet with were out of the office (no notice given). HR has been anything but helpful over the years when issues arose regarding pay discrepancies. We do not have PTO, paid holidays, etc. and are not reimbursed for mileage (I'm an off-site therapist)".
	"I was dissatisfied with the lack of training or even basic cultural awareness for my position. It was barely touched on".

Summary of Descriptive Statistics

The descriptive statistics for the continuous variables of the study are summarized in Table 17. It provides the scores for the mean, the standard deviation, the range of answers Participants, and the Cronbach's alpha of each continuous variable. The alpha scores for this study were well over the .7 threshold (Nunnally & Bernstein, 1994).

Table 17

Summary of Descriptive Statistics for Continuous Variables

Variable	N	M	SD	Range	Cronbach's Alpha
Affective Commitment Score	81	4.08	1.72	1-7	.92
Organization Socialization Score	81	5.50	.99	1-7	.91
Task Socialization	81	6.11	.80	1-7	.93
Job Satisfaction Score	81	4.04	.93	1-6	.96
Job Satisfaction-Pay facet	81	3.36	1.38	1-6	.85
Job Satisfaction-Promotion facet	81	3.29	1.12	1-6	.78
Job Satisfaction-Supervision facet	81	4.99	1.30	1-6	.90
Job Satisfaction-Fringe facet	81	3.58	1.30	1-6	.84
Job Satisfaction-Contingent Rewards facet	81	3.74	1.35	1-6	.87
Job Satisfaction- Operating facet	81	3.32	1.20	1-6	.75
Job Satisfaction-Coworker's facet	81	4.89	.96	1-6	.79
Job Satisfaction-Nature of work facet	81	5.06	.84	1-6	.82
Job Satisfaction- Communication facet	81	4.06	1.33	1-6	.87

Study Results

T-tests for Income and Prior Experience

There was a total of 104 respondents, but only 81of those fully completed the surveys. Originally, there were five predictor/control variables (salary, one/two household income, tenure, prior experience, and discipline) that required a minimum of 91 participants to run the multiple regression. Because 81 surveys did not allow me to run the regression with five variables, I dropped the controls to three variables, (discipline, salary, tenure) to run the regression. I then ran t-tests for prior experience and household income to look for significance. Tables 18 and 19 provide the results of the t-test.

Table 18

T-Test Results Comparing Job Satisfaction, Task Socialization, Organization Socialization, and Affective Commitment Between Those with and Without Prior FFS Experience

Variable	N	M	SD	T(df)	P-value
Organizational Socialization	Yes	27	5.4969	.05(79)	.96
	No	54	5.5076		
Task Socialization	Yes	27	6.0135	.78(79)	.44
	No	54	6.1620		
Affective Commitment	Yes	27	4.1605	.29(79)	.77
	No	54	4.0432		
Job Satisfaction	Yes	27	4.0247	.08(79)	.94
	No	54	4.0422		

The results of the t-tests indicate there was no significant difference between those with and without prior FFS experience on organization socialization. As a result of this finding, they were omitted and not included in the regression.

Table 19

T-Test Results Comparing Job Satisfaction, Task Socialization, Organization Socialization, and Affective Commitment Between One and Two Household Incomes

Variable	N	M	SD	T(df)	p-Value
Organizational Socialization	One Income	22	5.4280	. 37(78)	.71
	Two Income	58	5.5214		
Task Socialization	One Income	22	6.1901	.60(78)	.55
	Two Incomes	58	6.0693		
Affective Commitment	One Income	22	3.8333	.73(78)	.47
	Two Income	58	4.1494		
Job Satisfaction	One Income	22	3.8338	1.14(78)	.26
	Two Income	58	40995		

The results of the t-tests indicate there is no significant difference between clinicians having one and two-income households on organization socialization. As a result of this finding, they were omitted and not included in the regression.

Assumptions of Data Eligibility

For each individual research question, I tested the assumptions of linear regressions. The assumptions are:

- a linear relationship exists between independent and dependent variables which is tested with scatter plots.
- variables are normally distributed which is tested through the visual inspection of histogram and the Kolmogorov-Smirnoff test. If the histograms appear normal and the Kolmogorov-Smirnoff test is not significant, then the assumption is met;
- absence of multicollinearity. This is tested by examining the Variance Inflation factor (VIF). IVIF <10 indicates the assumption is met; and
- homoscedasticity (the variance of error terms is similar across the values of the independent variables) which is tested by plotting the standardized residuals against the predicted values. If the graph shows no pattern, the assumption is met.

The assumptions of data eligibility for all hypotheses were met except for task socialization. The histogram and the Kolmogorov-Smirnoff test indicated that the assumption of normality was met for job satisfaction and organization socialization, but not for task socialization.

Statistical Analysis

After going through the process of testing each assumption, I tested the hypotheses by running multiple regression. I also converted the categorical control variables into dichotomous

variables (e.g., social worker vs. counselor) without distinguishing the licensure level. After testing each assumption, I tested the hypotheses by running multiple regressions.

RQ1: What are the common job satisfaction factors for FFS clinicians?

This research question was answered with descriptive statistics. No assumptions were tested to run inferential statistics. The results provided a description of how job satisfaction factors were ranked. Table 20 provides the facets in a descending order from *mostly satisfied* (6) to *mostly* dissatisfied (1). It also provides the mean, the standard deviation, the alpha value scores for each. Lastly, it provides data about the total score for job satisfaction.

Table 20

Ranking of Job Satisfaction Factors

Variable	N	M	SD	Range	Cronbach's Alpha
Job Satisfaction- Nature of Work Facet	81	5.06	.84	1-6	.82
Job Satisfaction-Supervision Facet	81	4.99	1.30	1-6	.90
Job Satisfaction-Coworkers Facet	81	4.89	.96	1-6	.79
Job Satisfaction-Communication	81	4.06	1.33	1-6	.87
Job Satisfaction-Contingent Rewards Facet	81	3.74	1.35	1-6	.87
Job Satisfaction- Fringe Facet	81	3.58	1.30	1-6	.84
Job Satisfaction- Pay Facet	81	3.36	.1.38	1-6	.85
Job Satisfaction- Operating facet	81	3.32	1.20	1-6	.75
Job Satisfaction- Promotion Facet	81	3.29	1.12	1-6	.78
Job Satisfaction Total Score	81	4.04	.93	1-6	.96

There were nine factors for job satisfaction ranked from highest to lowest. Of the nine facets of job satisfaction, nature of work (M=5.06) ranked the highest area of satisfaction. Supervision was ranked the second highest (M=4.99) area of satisfaction, followed by the relationships with coworkers (M=4.89), and communication (M=4.06). Areas that scored lower were contingent rewards (M=3.74), fringe benefits (M=3.58), pay (M=3.36), and operating

(M=3.32). The least highly ranked area of satisfaction was opportunities for promotion scoring at (M=3.29). The total score for job satisfaction was (M=4.04).

Hypotheses Testing

RQ2: Does organizational socialization predict job satisfaction of FFS MH clinicians?

This research question has two hypotheses.

H1: Organization socialization is positively related to job satisfaction for FFS MH clinicians. The results of the linear regression reveal the model is significant [F (4,76) =16.360, p= <0.01, R-squared=.463, Part .607]. After controlling for tenure, salary, and license, there is significant relationship between organization socialization and job satisfaction [β=6.36, p-value<0.01]. The results reveal that when staff are provided with information about the organization's culture, programs, history, policies, and how their job function contributes to the larger organization (NSQ questionnaire), job satisfaction increases. As organization socialization increases, job satisfaction also increases. Tables 21 and 22 reflect the results.

Table 21

RQ1 H1 Model Summary

Model	R	R Square	Square	Estimate	Change	F Change	df1	df2	Sig. F Change	Durbin-Watson
1	.308[a]	.095	.059	.90685	.095	2.681	3	77	.053	
2	.680[b]	.463	.434	.70318	.368	52.064	1	76	<.001	1.576

[a] Predictors: (Constant), What is your salary range?, Social worker versus counselor, How long have you worked in your current organization/clinic ?

[b] Predictors: (Constant), What is your salary range?, Social worker versus counselor, How long have you worked in your current organization/clinic ?, Organization Socialization Score

Table 22

Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Correlations			Collinearity Statistics	
		B	Std. Error	Beta			Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	3.764	.275		13.681	<.001					
	How long have you worked in your current organization/clinic ?	-.041	.127	-.041	-.322	.749	.108	-.037	-.035	.738	1.355
	Social worker versus counselor	-.338	.224	-.168	-1.510	.135	-.102	-.170	-.164	.951	1.051
	What is your salary range?	.209	.085	.316	2.451	.017	.259	.269	.266	.707	1.414
2	(Constant)	.831	.459		1.811	.074					
	How long have you worked in your current organization/clinic ?	-.109	.099	-.109	-1.110	.270	.108	-.126	-.093	.731	1.368
	Social worker versus counselor	-.303	.174	-.151	-1.747	.085	-.102	-.196	-.147	.950	1.052
	What is your salary range?	.110	.067	.167	1.636	.106	.259	.184	.138	.678	1.474
	Organization Socialization Score	.601	.083	.636	7.216	<.001	.654	.638	.607	.910	1.099

[a.] Dependent Variable: Job Satisfaction Score

H2: Task socialization is positively related to job satisfaction for FFS MH clinicians. The Kolmogorov-Smirnoff test for task socialization was not met. The test results indicated that the assumption of normality was met for job satisfaction but not for the task socialization assumption. Figures 6 and 7 provide the illustrations of the results of the test.

Figure 6

Assumption for Job Satisfaction

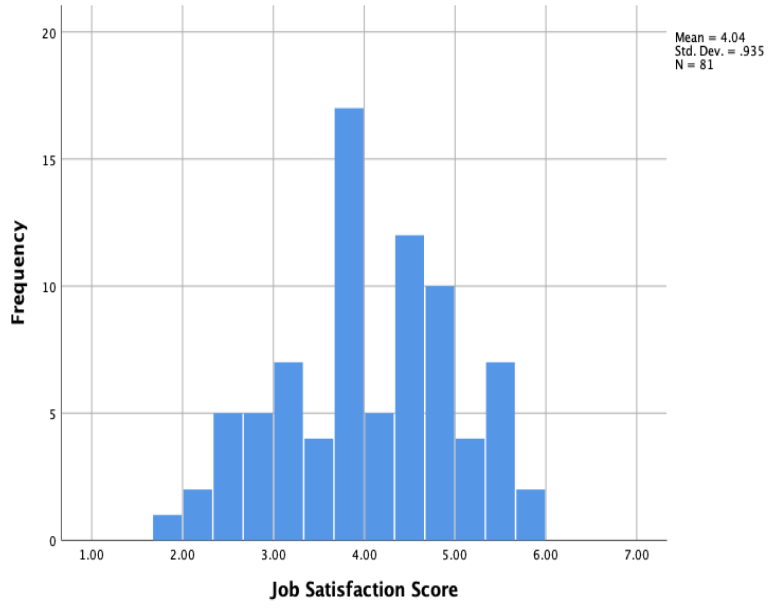
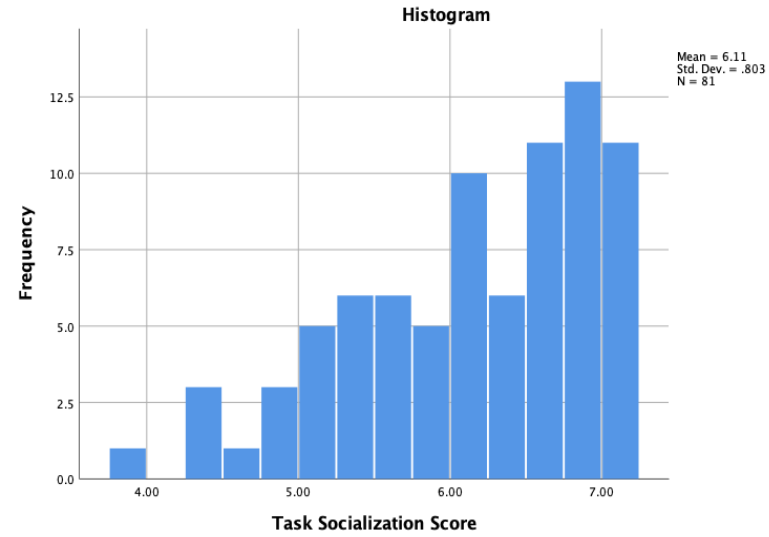


Figure 7

Assumption for Task Socialization



Despite TS not meeting the assumption test, I ran the multiple regression, and the model was significant [F (4,76) =16.360, p <0.01, R^2=.460, Part .605]. After controlling for tenure, salary, license, a significant relationship between task socialization and job satisfaction was revealed [β=.764, p < .001]. As task socialization increases, job satisfaction also increases. Tables 23 and 24 provide the results.

Table 23

Model Summary

					Change Statistics					
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	R Square Change	F Change	df1	df2	Sig. F Change	Durbin-Watson
1	.308[a]	.095	.059	.90685	.095	2.681	3	77	.053	
2	.678[b]	.460	.432	.70480	.366	51.477	1	76	<.001	1.364

[a.] Predictors: (Constant), What is your salary range?, Social worker versus counselor, How long have you worked in your current organization/clinic ?

[b.] Predictors: (Constant), What is your salary range?, Social worker versus counselor, How long have you worked in your current organization/clinic ?, Task Socialization Score

[c.] Dependent Variable: Job Satisfaction Score

Table 24

Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Correlations			Collinearity Statistics	
		B	Std. Error	Beta			Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	3.764	.275		13.681	<.001					
	How long have you worked in your current organization/clinic ?	-.041	.127	-.041	-.322	.749	.108	-.037	-.035	.738	1.355
	Social worker versus counselor	-.338	.224	-.168	-1.510	.135	-.102	-.170	-.164	.951	1.051
	What is your salary range?	.209	.085	.316	2.451	.017	.259	.269	.266	.707	1.414
2	(Constant)	-.488	.630		-.775	.441					
	How long have you worked in your current organization/clinic ?	-.218	.101	-.217	-2.150	.035	.108	-.239	-.181	.694	1.441
	Social worker versus counselor	-.176	.175	-.088	-1.004	.318	-.102	-.114	-.085	.935	1.069
	What is your salary range?	.134	.067	.203	2.000	.049	.259	.224	.169	.690	1.449
	Task Socialization Score	.764	.107	.656	7.175	<.001	.643	.635	.605	.849	1.177

[a.] Dependent Variable: Job Satisfaction Score

RQ3: Does organizational socialization impact affective commitment?

This research question has three hypotheses.

H3: Organization socialization is positively related to affective commitment of FFS clinicians. The results of the linear regression reveal that the model is significant [F (4,76) = 121.07, p <.001, R^2=.389, part .552]. After controlling for tenure, salary, and license, a significant relationship exists between organizational socialization and affective commitment [β =.579, p<.001]. As organizational socialization increases, affective commitment also increases. Tables 25 and 26 display the results.

Table 25

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics					Durbin-Watson
					R Square Change	F Change	df1	df2	Sig. F Change	
1	.291[a]	.084	.049	1.67637	.084	2.367	3	77	.077	
2	.624[b]	.389	.357	1.37818	.305	37.924	1	76	<.001	.870

[a.] Predictors: (Constant), What is your salary range?, Social worker versus counselor, How long have you worked in your current organization/clinic ?

[b.] Predictors: (Constant), What is your salary range?, Social worker versus counselor, How long have you worked in your current organization/clinic ?, Organization Socialization Score

[c.] Dependent Variable: Affective Commitment Score

Table 26

Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Correlations			Collinearity Statistics	
		B	Std. Error	Beta			Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	3.692	.509		7.259	<.001					
	How long have you worked in your current organization/clinic ?	-.031	.234	-.017	-.132	.895	.109	-.015	-.014	.738	1.355
	Social worker versus counselor	-.695	.413	-.188	-1.681	.097	-.129	-.188	-.183	.951	1.051
	What is your salary range?	.334	.158	.275	2.119	.037	.225	.235	.231	.707	1.414
2	(Constant)	-1.214	.900		-1.349	.181					
	How long have you worked in your current organization/clinic ?	-.146	.193	-.079	-.755	.453	.109	-.086	-.068	.731	1.368
	Social worker versus counselor	-.637	.340	-.172	-1.873	.065	-.129	-.210	-.168	.950	1.052
	What is your salary range?	.169	.132	.139	1.279	.205	.225	.145	.115	.678	1.474
	Organization Socialization Score	1.005	.163	.579	6.158	<.001	.595	.577	.552	.910	1.099

[a.] Dependent Variable: Affective Commitment Score

H4: Task socialization positively impacts affective commitment of FFS MH clinicians. The results of the linear regression reveal the model for this hypothesis is significant [F (4, 76) =5.406, p <.001, R^2= .221, part=.370]. After controlling for tenure, salary, and license, a significant relationship between task socialization and affective commitment exists. [β=.402, p <.001]. As task socialization increases, affective commitment also increases. Table 27 and 28 provide the results.

Table 27

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics					Durbin-Watson
					R Square Change	F Change	df1	df2	Sig. F Change	
1	.291[a]	.084	.049	1.67637	.084	2.367	3	77	.077	
2	.471[b]	.221	.181	1.55594	.137	13.381	1	76	<.001	.450

[a.] Predictors: (Constant), What is your salary range?, Social worker versus counselor, How long have you worked in your current organization/clinic ?

[b.] Predictors: (Constant), What is your salary range?, Social worker versus counselor, How long have you worked in your current organization/clinic ?, Task Socialization Score

[c.] Dependent Variable: Affective Commitment Score

Table 28

Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Correlations			Collinearity Statistics	
		B	Std. Error	Beta			Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	3.692	.509		7.259	<.001					
	How long have you worked in your current organization/clinic ?	-.031	.234	-.017	-.132	.895	.109	-.015	-.014	.738	1.355
	Social worker versus counselor	-.695	.413	-.188	-1.681	.097	-.129	-.188	-.183	.951	1.051
	What is your salary range?	.334	.158	.275	2.119	.037	.225	.235	.231	.707	1.414
2	(Constant)	-1.094	1.391		-.787	.434					
	How long have you worked in your current organization/clinic ?	-.230	.224	-.125	-1.029	.307	.109	-.117	-.104	.694	1.441
	Social worker versus counselor	-.513	.387	-.139	-1.326	.189	-.129	-.150	-.134	.935	1.069
	What is your salary range?	.250	.148	.206	1.687	.096	.225	.190	.171	.690	1.449
	Task Socialization Score	.860	.235	.402	3.658	<.001	.425	.387	.370	.849	1.177

[a.] Dependent Variable: Affective Commitment Score

H:5 Organizational socialization is positively related to affective commitment. After running task and organization socialization variables independently, I wanted to investigate the combined components of organizational socialization to examine its relationship with the affective commitment of FFS clinicians. The results of the linear regression model revealed that, when these two variables are combined, the model is only partially significant for organization socialization but and not task. The results of the regression revealed a p .940 (part= .007) once organization socialization is accounted for. Tables 29 and 30 illustrate the models.

Table 29

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics					Durbin-Watson
					R Square Change	F Change	df1	df2	Sig. F Change	
1	.291[a]	.084	.049	1.67637	.084	2.367	3	77	.077	
2	.624[b]	.389	.357	1.37818	.305	37.924	1	76	<.001	
3	.624[c]	.389	.349	1.38729	.000	.006	1	75	.940	.871

[a.] Predictors: (Constant), What is your salary range?, Social worker versus counselor, How long have you worked in your current organization/clinic ?

[b.] Predictors: (Constant), What is your salary range?, Social worker versus counselor, How long have you worked in your current organization/clinic ?, Organization Socialization Score

[c.] Predictors: (Constant), What is your salary range?, Social worker versus counselor, How long have you worked in your current organization/clinic ?, Organization Socialization Score, Task Socialization Score

[d.] Dependent Variable: Affective Commitment Score

Table 30

Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Correlations			Collinearity Statistics	
		B	Std. Error	Beta			Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	3.692	.509		7.259	<.001					
	How long have you worked in your current organization/clinic ?	-.031	.234	-.017	-.132	.895	.109	-.015	-.014	.738	1.355
	Social worker versus counselor	-.695	.413	-.188	-1.681	.097	-.129	-.188	-.183	.951	1.051
	What is your salary range?	.334	.158	.275	2.119	.037	.225	.235	.231	.707	1.414
2	(Constant)	-1.214	.900		-1.349	.181					
	How long have you worked in your current organization/clinic ?	-.146	.193	-.079	-.755	.453	.109	-.086	-.068	.731	1.368
	Social worker versus counselor	-.637	.340	-.172	-1.873	.065	-.129	-.210	-.168	.950	1.052
	What is your salary range?	.169	.132	.139	1.279	.205	.225	.145	.115	.678	1.474
	Organization Socialization Score	1.005	.163	.579	6.158	<.001	.595	.577	.552	.910	1.099
3	(Constant)	-1.150	1.240		-.928	.357					
	How long have you worked in your current organization/clinic ?	-.142	.201	-.077	-.709	.480	.109	-.082	-.064	.688	1.454
	Social worker versus counselor	-.641	.346	-.173	-1.851	.068	-.129	-.209	-.167	.929	1.076
	What is your salary range?	.169	.133	.139	1.272	.207	.225	.145	.115	.678	1.475
	Organization Socialization Score	1.017	.224	.585	4.539	<.001	.595	.464	.410	.490	2.042
	Task Socialization Score	-.021	.286	-.010	-.075	.940	.425	-.009	-.007	.457	2.188

[a.] Dependent Variable: Affective Commitment Score

H6: Job satisfaction is positively related to affective commitment of FFS MH clinicians. The results of the linear regression reveal the model is significant [F (4,76) = 21.682, p <.001, R^2 =.533, part. 670]. After controlling for tenure, salary, and license, a significant relationship was

found between job satisfaction and affective commitment [β = .704, p < .001]. As job satisfaction increases, affective commitment also increases. Tables 31 and 32 provide the results of the output.

Table 31

Model Summary

					Change Statistics				
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	R Square Change	F Change	df1	df2	Sig. F Change
1	.291[a]	.084	.049	1.67637	.084	2.367	3	77	.077
2	.730[b]	.533	.508	1.20514	.449	72.989	1	76	<.001

[a.] Predictors: (Constant), Social worker versus counselor, How long have you worked in your current organization/clinic ?, What is your salary range?

[b.] Predictors: (Constant), Social worker versus counselor, How long have you worked in your current organization/clinic ?, What is your salary range?, Job Satisfaction Score

[c.] Dependent Variable: Affective Commitment Score

Table 32

Coefficients

		Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B		Correlations			Collinearity Statistics	
Model		B	Std. Error	Beta	t	Sig.	Lower Bound	Upper Bound	Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	3.692	.509		7.259	<.001	2.679	4.704					
	How long have you worked in your current organization/clinic ?	-.031	.234	-.017	-.132	.895	-.497	.435	.109	-.015	-.014	.738	1.355
	What is your salary range?	.334	.158	.275	2.119	.037	.020	.648	.225	.235	.231	.707	1.414
	Social worker versus counselor	-.695	.413	-.188	-1.681	.097	-1.518	.128	-.129	-.188	-.183	.951	1.051
2	(Constant)	-1.178	.677		-1.740	.086	-2.527	.170					
	How long have you worked in your current organization/clinic ?	.022	.168	.012	.129	.897	-.313	.357	.109	.015	.010	.737	1.357
	What is your salary range?	.064	.118	.052	.541	.590	-.171	.298	.225	.062	.042	.656	1.524
	Social worker versus counselor	-.258	.302	-.070	-.856	.395	-.859	.343	-.129	-.098	-.067	.924	1.083
	Job Satisfaction Score	1.294	.151	.704	8.543	<.001	.992	1.595	.726	.700	.670	.905	1.104

[a.] Dependent Variable: Affective Commitment Score

Hierarchical Linear Regression

After running the regressions and finding significant relationships between the variables, I investigated the importance of job satisfaction and whether the degree of its significance to affective commitment was more "above and beyond" than organization and task socialization.

One model used OS, TS, and for the second model, I added job satisfaction. The output indicated that job satisfaction significance was much higher as presented in the score of the F change from model 1 to model 2 was 40.035. This highlighted the role of job satisfaction in predicting affective commitment even after accounting for organization and task socialization. Tables 33 and 34 display the results.

Table 33

Model Summery

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	R Square Change	F Change	df1	df2	Sig. F Change	Durbin-Watson
1	.595[a]	.354	.337	1.39925	.354	21.356	2	78	<.001	
2	.758[b]	.575	.558	1.14231	.221	40.035	1	77	<.001	1.200

[a.] Predictors: (Constant), Organization Socialization Score, Task Socialization Score

[b.] Predictors: (Constant), Organization Socialization Score, Task Socialization Score, Job Satisfaction Score

[c.] Dependent Variable: Affective Commitment Score

Table 34

Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Correlations		
		B	Std. Error	Beta			Zero-order	Partial	Part
1	(Constant)	-1.694	1.202		-1.409	.163			
	Task Socialization Score	.030	.274	.014	.109	.913	.425	.012	.010
	Organization Socialization Score	1.016	.222	.585	4.569	<.001	.595	.459	.416
2	(Constant)	-.936	.989		-.947	.347			
	Task Socialization Score	-.485	.238	-.226	-2.035	.045	.425	-.226	-.151
	Organization Socialization Score	.559	.195	.322	2.859	.005	.595	.310	.212
	Job Satisfaction Score	1.215	.192	.661	6.327	<.001	.726	.585	.470

[a.] Dependent Variable: Affective Commitment Score

Summary

This study examined the relationships between OS, JS and AC of FFS MH clinicians. This study is important as the shortage for MH clinicians has reached a critical level creating delays in treatment due to waitlists and high turnover. To meet the demands of the mentally ill while taking care of the needs of MH clinicians, leaders can benefit from look for opportunities

to improve the working conditions within their FFS organizations. Between February 12 and March 7, 2021, the study surveyed 81 clinicians anonymously using three vetted instruments. The questions gathered information about participant demographics, socialization experiences, level of job satisfaction, and desire to stay within their organizations. The information was uploaded to SPSS 27 and inferential statistics was used to explore relationships among the variables- task socialization, organization socialization, organizational socialization, job satisfaction, and affective commitment. The study findings suggest that there are positive relationship organizational socialization activities and the level of job satisfaction and commitment.

This chapter described the study data analysis that examined predictors for job satisfaction and commitment for FFS MH clinicians. The study provided descriptive statistics, t-tests, and regression analyses. Demographic information of the 81 clinicians who completed the survey revealed that the majority of the respondents were White females ranging between 23 and 71 years of age. Almost half the participants had been employed for less than 2 years, but most had been in their profession between 3-5 years. Over half of the respondents were social workers. Of the social workers, most held LCSW-Cs. Within the sample, respondents reported they were *mostly satisfied* with the nature of their work, their supervisor, and their coworkers. Less were satisfied with their pay, polices, and opportunities for promotion. T-tests revealed no significance between one or two household income, prior experience on organizational socialization, job satisfaction and commitment. Additionally, no significance was found between social work and counseling on job satisfaction and commitment. Linear regression analyses that tested organization socialization and task socialization as predictors of job satisfaction showed that they were statistically significant predictors, with a moderate effect size of .463 and .460

respectively. Organization socialization also predicted affective commitment with a slightly lower effect size of .389. Task socialization, although a predictor of affective commitment, had the lowest effect size of .221. Job satisfaction, on the other hand, had the strongest effect size of .533 for commitment. To further evaluate the role of job satisfaction, I ran a hierarchical linear regression and tested different models to evaluate the effect of the variables on commitment. When job satisfaction was added to the model, it revealed that the degree of job satisfaction's significance on commitment was much higher than organization socialization and task socialization. Table 35 provides a summary of findings.

Table 35

Summary of Hypotheses Finding

Hypothesis	Finding
H1: Organization socialization is positively related to job satisfaction	Supported
H2: Task socialization is a positively related to job satisfaction.	Supported
H3: Organizational socialization is positively related to affective commitment.	Partially Supported
H4: Organization socialization is positively related to affective commitment.	Supported
H5: Task socialization is positively related to affective commitment.	Supported
H6: Job satisfaction is positively related to affective commitment	Supported

CHAPTER 5: CONCLUSIONS AND IMPLICATIONS

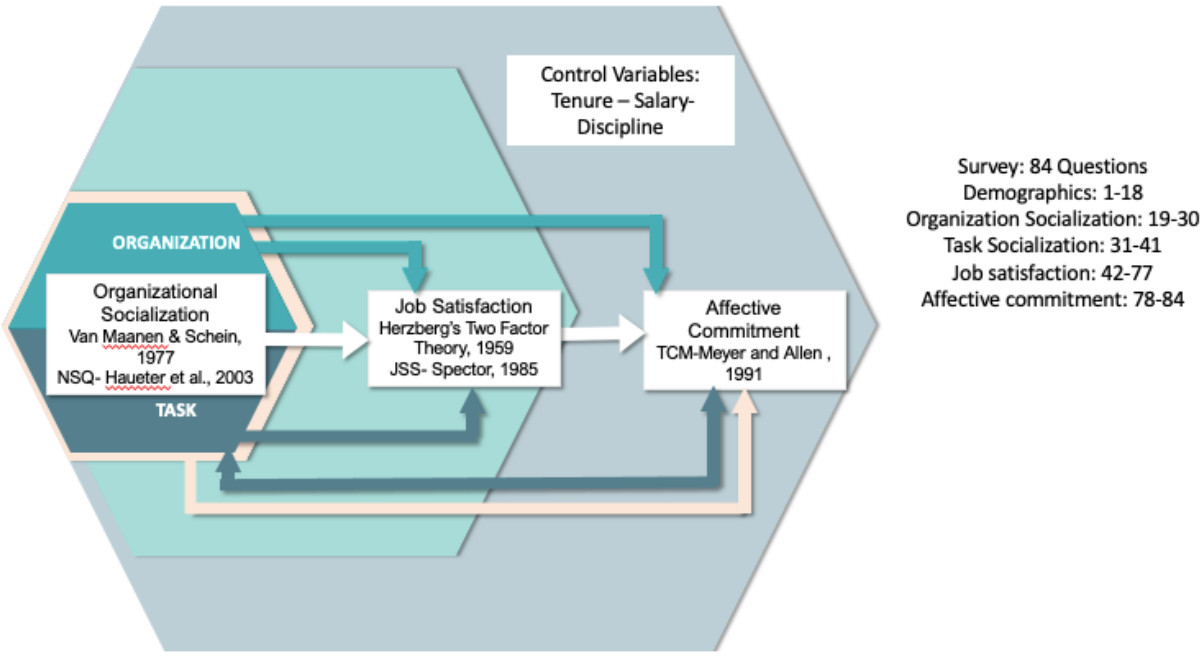
This study investigated the influence of organizational socialization on job satisfaction (organization, task) and commitment of FFS mental health (MH) clinicians. The literature review explored the importance of socialization practices for satisfaction and commitment within different career fields and factors that influence level of satisfaction. It also spotlighted the absence of data for FFS MH clinicians. Filling this gap with evidence-based research is crucial for leaders within the MH FFS industry to improve their practices to promote individual and organizational success. This chapter includes a discussion of the study findings, limitations of the study, followed by implications for leaders, human resources personnel, and higher education institutions. The chapter closes with recommendations for future research.

Discussion

This study focused on factors influencing job satisfaction and affective commitment of FFS MH clinicians. It specifically examined the impact of organizational socialization and its relationship with affective commitment. Socialization practices are intended to provide newly hired clinicians with the tools, skills, knowledge, and training to transition to their new position. To achieve success, FFS administrators need to examine their practices to strike a balance between several competing priorities that are unique for FFS clinicians. These priorities are comprised of offering staff socialization practices that include specific strategies designed to promote excellence in the delivery of service, autonomy, and productivity. These include managing caseloads and addressing no shows and cancellations while providing excellent clinical services. Another priority for leaders to make every effort to ensure that staff provide billable services to receive a paycheck. The fully framework of this study is presented in Figure 8.

Figure 8

Conceptual and Theoretical Framework with the Measurement Model



The illustration provides the full model that guided this study. The framework includes the constructs of organizational socialization, job satisfaction, and affective commitment. Additionally, the framework provides the three theories (Van Mannen & Schein's theory of socialization (1977), Herzberg's two factor job satisfaction theory, Meyer and Allen's TCM model of commitment) that provided the blueprint for the study, and the control variable (tenure, salary, and discipline). Lastly, it offers the three validated instruments (the NSQ, the JSS, and the AC) with questions associated with measuring each construct.

The study was shared with over 2,500 clinicians and, despite the repeated reposting/ resharing of the survey link in efforts to recruit more respondents, there was 104 surveys. Of the 104, 23 were removed due to missing data, leaving a total of 81 surveys. Originally, the study had five control variables (tenure, salary, discipline, one/two income household, and prior FFS

experience), and to run the regression with five control variables, a minimum of 91 participants was needed. Because my final sample size was 81, I was not able to run the regression with five control variables. As a result, I dropped prior experience and one/two household income, but not before running t-tests on the two variables comparing JS, TS, OS, and AC. The results of the t-tests revealed no significance. The remaining control variables that were used for the study were tenure, salary, and discipline. The following sections discuss the research findings within the confines of the research questions and related hypotheses.

A total of 81 FFS clinicians participated in the study. The socio-demographic profile findings of this study were consistent with the field of mental health where White females are the dominant race and gender in the profession. This was reported in a 2020 labor force statistics population survey (BLS, 2021). In the category of community and social service occupations, 16 occupations were listed along with their socio-demographics profile. Table 36 provides the different categories specifying occupations that were best matched with the sample of this study. Table 36 also details employed persons by occupation, sex, race, and Hispanic or Latino ethnicity. Averages are given in thousands.

Table 36

2020 Household Data Annual Averages

	Total Employed	Women	White	Black, African American	Asian, Asian American	Hispanic or Latino
Community and social service occupations	2717	68.8	72.7	19.9	3.4	13.5
Substance abuse and behavioral disorder counselors * (SABDC)	130	81.3	70.2	25.4	1.7	16.8
Educational., guidance, and career counselors and advisors	343	77.8	73.0	19.0	4.0	14.8
Marriage and family therapists* (MFT)	40	-	-	-	-	-
Mental health counselors* (MHC)	138	72.9	87.5	9.4	2.0	14.0
Rehabilitation counselors	28	-	-	-	-	-
Counselors, all other	225	68.2	75.0	18.3	3.7	15.2
Child, family, and school social workers	62	89.8	65.3	26.8	.6	21.3
Healthcare social workers	78	87.0	69.0	20.3	8.2	9.2
Mental health and substance abuse social workers* MHSASW)	24	-	-	-	-	-
Social workers, all other	673	85.4	64.4	25.7	3.7	15.0
Probation officers and correctional treatment specialists	105	50.7	66.6	26.9	0.7	12.8
Social and human service assistants	673	85.4	64.4	25.7	3.7	15.0
Other community and social service specialists	100	77.6	61.6	30.4	3.3	12.7
Clergy	420	18.5	82.3	11.7	3.8	7.8
Directors, religious activities and education	57	64.9	94.4	2.4	2.1	8.9
Religious workers, all other	64	71.5	77.7	13.4	6.2	11.7

Note. *Categories that are the best match representing the sample of this study are taken from the 2020 Bureau of Labor Statistics (2021) survey.

The four categories that best matched the sample of this study were mental health counselors (MHC), substance abuse and behavioral disorder counselors (SABDC), mental health and substance abuse social workers (MHSASW), and marriage and family therapist (MFT). When looking at their socio demographic profile, women ranked the highest in the survey ranging between 72.9% for mental health counselors to 81.3% for substance abuse and behavioral disorder counselors. When looking at the entire category of community and social service occupation categories, females were the highest at 68%. These numbers suggest that the

field is predominantly female occupied with the number of male clinicians limited. These numbers were consistent with the sample of this study in which 74 (91.4%) were female clinicians compared to 7 (86%) male clinicians. The racial composition in the BLS survey consisted of predominantly Whites ranging between 70.2% (SABDC) and 87.5% (MHC). The full occupation category comes in at 72.7% suggesting that most of the professionals who completed the survey were White. Blacks ranged between 9.4% (MHC) and 25.4 (SABDC). The total for the category was 19.9%. The sample of this study was not consistent with the 2020 survey as the number of Black clinicians who completed the survey was only 4 (4.9%). Currently, there is a great need for clinicians, in general, but an even greater need for clinicians of color. With the recent surge of racial tensions and violence, more non-White clients are seeking clinicians of color to meet their mental health needs. The lack of diversity among clinicians is further delaying treatment for individuals who are struggling with the impact of current events and are opting to be waitlisted for a Black clinician instead of an available White clinician. The percentage for Hispanic or Latino clinicians (7.4%) who completed the survey was also lower than the 14% to 21% reported in the 2020 survey (BLS, 2021). The overall percentage of Asians within the community clinic and social service category was 3.4%. Examining the category for the best matched occupations reveals the percentage ranges between 1.7% for SABDC to 2.00% for MHC. Within the study there were three (3.7%) participants who identified as being Asian. Finally, when comparing the number of Hispanics or Latinos within the study's sample to the 2020 BLS survey, the study's number is lower than the 2020 survey's number. Of the 81 study participants, six (7.4%) identified as Hispanics and Latinos where the overall percentage of Hispanics and Latinos in the 2020 survey was 13.5% for the entire category of the occupations. When looking at occupations similar to the participants of the sample, 16.8% were

SABDC and 14.8% were MHC. Of note, there were two categories that fit the profile of the study's sample. Those were MFT, and MHSASW, but the two categories did not list any demographic information as the overall sample was small. The demographic data in this study continues to highlight the lack of diversity within the profession.

Salaries of the participants ranged between $25,000 to over $150,000. Of the 81 participants 18 (22.2%) reported a salary between $25,000 and $49,000. Twenty (24%) reported salaries of $50,000 to $64,999, 18 (22.2%) ranged between $65,000 to $74,000, 18 (16%) reported a range of $75,000 to $99,000, 5 (6.2%) reported a range of $100,000 to $150,000, and, lastly, 4 (4.9%) reported income over $150,000 (see Table 9 in chapter 4). 24% reported income above the median salary provided by the 2020 Bureau of Labor and Statistics survey that listed the median salary for social workers at $51,760 and counselors at $51,350 (BLS, 2021). In 2019, the U.S. Bureau of Labor and Statistics (BLS) listed the average median salary for a full-time master-level licensed marriage and family therapists to be $49,610 and $50,470, respectively. These numbers cannot be generalized to suggest that the field's overall compensation has been elevated, but the results of this study provide hope that mental health clinicians can earn better wages. In terms of cost of living and reimbursement rates, Maryland's (MD) Public Behavioral Health System's (PBHS) reimbursement rate is the same across all counties. For example, the current rate of evaluation for an adolescent who has MD Medicaid is $208.41. Therefore, a clinician who works in Frederick County will get the same reimbursement rate as a clinician working in Montgomery County, if they have the same licensure and experience. However, depending on their reimbursement rate negotiated with their employer their take home can vary. This means that clinicians who live in areas with lower cost of living can potentially earn better wages when working in counties where the cost of living is higher. It is, however, concerning

that 18 participants reported an income range of $25,000 to $49,000. This may be due to lack of socialization strategies, new employment, new to the field, or other environmental factors.

The number of participants carrying advanced licensure was high as 38 held LCSW_C and 17 possessed LCPC licensures. This was surprising as most clinicians who acquire advanced licensure tend to leave community clinics and opt to open practices on their own. The population sample of the study provides hope for OMHCs to retain staff with advanced licensure and experience, as opposed to new clinicians trying to gain experience, supervision, and wanting to build their skills. Additionally, the result of this study suggests that OMHCs are providing effective socialization skills and are successful in keeping advanced and seasoned staff engaged and committed.

Common Job Satisfaction Factors

Spector (1985) identified nine common job satisfaction factors that measure level of employee satisfaction for human service workers. The instrument has been used within different disciplines and countries. Within the mental health field, prior research has found the nature of work to be a primary reason for individuals to join the field. Because FFS clinicians' compensation is decided by services rendered, their take-home pay can be compromised, as no shows and cancellations are not reimbursable. This challenge can potentially take away the joy of being in the helping field. Salaried clinicians do not have this barrier as their financial stability is not governed by clients but by their organizations. For this reason, I wanted to explore and identify important factors that could differ from other human service workers. The findings of this study indicated that the overall level of job satisfaction factors was high. Staff ranked their satisfaction with nature of work receiving the highest and promotion receiving the lowest level of satisfaction. Supervision, communication, and relationship with coworkers were ranked

moderately high. These findings are consistent with prior research that examined the tenets of job satisfaction (Batura et al., 2016; Busaltic &Musabasic, 2018; Calitz & Strydom, 2014). This research did not investigate the individual facets of job satisfaction. The purpose of the first research question (What are common job satisfaction factors for FFS MH clinicians?) was to fill the gap in existing literature to identifying job satisfaction factors and ascertain if they differed from clinicians who were employed in salaried positions. The results of this study suggest that nature of work is considered to be an area that mental health clinicians enjoy the most, regardless of their pay structure.

Impact of Organizational Socialization on Satisfaction

The study focused on organizational socialization strategies and their relationship with job satisfaction. Since the Industrial Revolution, the constructs of organizational socialization and job satisfaction have been studied extensively. These studies examined relationships between staff's socialization experiences and their level of job satisfaction (Ashforth et al., 1996; Bauer & Erdogan, 2011; Bauer et al., 2015; Ćulibrk et al., 2018; Green et al., 2014; Jones, 1986; Van Maanen & Schein, 1979,) Several socialization theories emerged to provide employers a guide on how to increase job satisfaction.

Van Maanen and Schein's theory of organizational socialization provided the framework for this study. The theory offers specific strategies that companies can adopt in the process of orienting new staff. The theory offers two different ways of using these tactics that can either be individualized or collective. It further offers specific positions where these tactics can be most beneficial. To effectively socialize FFS clinicians, tactics that can be most beneficial are the ones that are formal, collective, sequential, and variable. The FFS clinician position requires discipline, organizational skills, and consistency. When the first week of employment begins

without structured activities and staff are left to their own devices to acquire the knowledge, skills, and job objectives, an opportunity to engage staff is lost. The FFS clinician position itself is informal and offers an unstructured schedule and high level of autonomy. When a *laissez faire* attitude is promoted early on, administrators lose the opportunity to teach, train, and coach staff to create structure within an unstructured position. Therefore, informal., individual socialization may not be effective for FFS organizations. Despite the theory's premise that the absence of formal, collective socialization, pushes individuals to be creative in acquiring the knowledge, skills, and attitudes to learn the position. There is an argument to be made that an informal *laissez faire* approach might be effective in salaried positions as there is no compromise between learning the ropes and earning a living. In salaried environments, new staff spend their first days and weeks getting acquainted to the position, coworkers, and job functions. Time spent in learning the position is encouraged without having to ask clinicians to sacrifice their pay. New employees' focus is to learn their responsibilities without worrying about their paychecks. They know if they report to work at their designated time, they will be compensated. In comparison, FFS mental health clinicians do not have the luxury of getting acclimated to their new position. Beginning a new position is stressful and can be intimidating as individuals are trying to acclimate to new routines, responsibilities, and supervisors (Chao, 2012; Haueter, 2003; Jones, 1986; Tuttle; 2002; Van Maanen & Schein, 1979). Therefore, leaders, human resource personnel may want to explore a different compensation structure to avoid problems discusses earlier. Such strategies can include compensating staff for at least 30 days while providing them with formal structured socialization.

In many OMHCs, FFS clinicians' first week is laden with information about the organization, policies, tasks, and billing rules as well as learning the Code of Maryland

Regulations (COMAR) pertaining to reporting abuse, documentation, best practice guidelines and other pertinent information (anonymous personal communication with various staff from different OMHCs 2018-2021). Their transition from being an outsider to an insider (Bauer, 2011) is expected to take place quickly with an emphasis on billing to generate revenue for compensation. This can be overwhelming as staff might not fully grasp the information to apply to practice; yet they are given cases within the first 7 days. In addition to the stressors associated with navigating their new position and learning their tasks, FFS clinicians have the extra challenge of no shows, cancellations, and noncompliance. When clients do not show up for treatment and cancel their appointments, FFS MH clinicians do not receive compensation. These factors can impact their job satisfaction levels early on.

Within this study, participants reported receiving onboarding strategies and cases between one to seven days. This means that, while they were receiving their socialization practices, they were assigned cases simultaneously and had to balance learning with scheduling appointments. This can be quite daunting when staff do not accumulate enough knowledge within the first week to successfully schedule and provide treatment. Organizations may want to consider these issues when expecting increased productively and commitment. These expectations may be unrealistic given that clinicians are concerned with meeting their financial responsibilities. Leaders within organizations can help staff accomplish better performance when effective strategies are used. Certainly, the results of this study highlighted the relationship between organizational strategies and job satisfaction and commitment. When staff receive sufficient tools, practices, and guidance, their individual successes can contribute towards achieving organizational success. This attitude then can increase both satisfaction, commitment,

and, ultimately, reduce turnover. Therefore, providing effective socialization can be vital to increasing employees job satisfaction and commitment.

Within this study, 45 participants reported getting compensated for their organizational socialization experiences and most received their cases within the first week of employment. Of the 81 participants, 62 reported receiving organizational socialization that lasted between one to seven days. Although the demographic variables were not tested independently with job satisfaction, the seven days of onboarding may have contributed to increasing their job satisfaction, as the data analysis revealed significant relationships between organization and task socialization with job satisfaction. The study did not examine individual variables to test the relationship with the constructs; therefore, it is not possible to say that participants' job satisfaction was related to the length or the quality of their onboarding. The inability to claim a relationship between length of onboarding and job satisfaction can lend itself for future research. The next section explores Herzberg's motivation and hygiene factors.

Herzberg's two-factor motivation theory provided the second framework for the study. The theory identifies hygiene and motivator dimensions that either increase satisfaction or decrease dissatisfaction. As discussed in the earlier chapters, the two dimensions are independent of one another and are not an inverse relationship. Hygiene factors include salary, supervision, work conditions, and policies that decrease employee dissatisfaction, whereas motivator factors are promotion, nature of work and contingent rewards. Compensation is considered both a motivator and a hygiene factor. Within FFS OMHCs compensation, autonomy, and flexibility are often highlighted to illustrate the benefits of this type of position during recruitment. In terms of compensation, recruits are informed of their ability to determine potential earnings based on the number of sessions they provide. Flexibility and autonomy are other highlighted topics

during the interview. Personnel conducting the interviews, point out the autonomous nature of creating flexible schedules that can suit their individual lifestyle and the ability to have a work life balance. As stated in the results section in Chapter 4, the three factors that ranked the lowest were promotional opportunities (M= 3.29), policies (M=3.32), and pay (M=3.36).

Within the study, promotional opportunities were an area of concern within the study. Promoting individual growth and a clear path towards success is something that needs to be addressed. Although income alone cannot be a motivator, research suggests that pay and promotional opportunities can make a difference in employee retention (Chamberlain, 2017) and satisfaction (Mabaso & Dlamini, 2017). Lack of advancement opportunities is another reason staff choose to leave a position. A 2020 retention survey reported that 20% of staff leave due to lack of career development opportunities (Mahan et al., 2020) which can be similar to lack of promotional advancements. Because individual variables were not individually test with job commitment, it is not possible to draw conclusions about the importance of promotional opportunities to clinicians' commitment to stay within their organization.

Polices were ranked as 2nd lowest job satisfaction factor. Based on Herzberg's theory this is one of the hygiene factors that is considered an area that causes dissatisfaction in the workplace. This finding was not very surprising as company policies and procedures tend to frustrate staff specially if they are outdated and not practical. An example of an area of dissatisfaction for FFS MH clinician can be non-clinical administrative clerical work such dealing with insurance companies to address denials and writing and mailing letters. Leaders within the field, may want to focus on these areas and set a process of supporting clinicians by taking away the clerical work to allow clinicians to focus on their clinical work.

Lastly, pay was also an area of concern that the results of this study revealed. Eighteen clinicians reported income between $25,000 and $49,000 which, as discussed previously, is lower than other fields that require less education. For example, the median income for a bachelor-level teacher is $61,660 (BLS, 2019) and for a teacher with a master's degree, the median salary is $77,187 (MSDE, 2018). The nursing field is another example. The annual median salary for a registered nurse ranges between $63,170 and $75,310 depending on the type of employment setting (BLS, 2019). It is unclear if the 18 clinicians' income is reflective of their choice to work less, lack of strategies and training provided during socialization that could enable them to achieve a higher salary, or their tenure within the field or the organization. Administrators who want to drive organizational success can benefit from monitoring their staff's progress and offer guidance, support, coaching, and supervision to help clinicians achieve their desired salaries. If administrators expect commitment from their staff, then they too can benefit from providing the necessary resources to promote productivity and success.

Finally, findings of this study highlighted that it did not matter that FFS MH clinicians do not have fixed incomes and can work independently, their job satisfaction factors are consistent with what previous research has identified as motivators and hygiene factors. Herzberg's theory still holds true after all these years and not much has changed regarding human behavior and ways that staff can be motivated. It is interesting though that, with all the advancement in knowledge and technology, high turnover and lack of commitment continue to be identified as areas of concern for organizations. Although there is limited research about FFS MH clinicians and their onboarding experiences, the results of this study were consistent with other research findings within different fields such as banking (Abdallah et al., 2017), nurse practitioners (Koelbel, et al., 1991) school counselors (Gabberly & Osborn, 2006), and hotel managers

(Carbery et al., 2003). Within this study, task socialization (specific functions to perform job duties) revealed a positive relationship with job satisfaction while organization socialization (information about the history, culture, mission, and vision and meeting senior executives) also were shown to influence job satisfaction. Consistent with prior research, organizational socialization predicted job satisfaction (Bauer & Erdogan, 2011; Chao et al., 1994; Ćulibrk et al., 2018; De Gieter et al., 2011).

Van Maanen & Schein (1977) and Herzberg's (1959) job satisfaction theories complement one another in this study. Offering organizational socialization can perpetuate positive feeling and increase a sense of satisfaction. Herzberg reported intrinsic and extrinsic factors that motivate and demotivate staff. When new staff are offered organizational socialization, which are extrinsic factors such policies, supervision and work environment, staff feel supported, have resources, guidance and clarity early on and they develop a positive attitude toward their employer. Upon entry to a new organization, FFS clinicians are excited about the prospect of the new position with its promise to earn a high income and have the flexibility of managing their own caseloads and schedules. They are potentially motivated but may not necessarily report a high level of job satisfaction. They are looking to learn policies, learn the culture, get to know their supervisor, and provide clinical services. The sooner clinicians feel that they have learned everything about the company and have adequate knowledge to perform their job duties, the sooner they will begin developing feelings of connectedness and fondness towards their organizations. Chapter 2 included an extensive discussion of the benefits of organizational socialization and its relationship with job satisfaction. The literature review indicated that the more organizational socialization they receive, the sooner they begin to develop feelings of fondness. Therefore, organizational socialization can be viewed as antecedent to the job

satisfaction of FFS MH clinicians. The findings of this study revealed that organizational socialization predicted job satisfaction.

Impact of Job Satisfaction on Affective Commitment

Kumar and Saini (2012) reported that, when employees develop positive attitudes about their employment, they become invested to the organization and most likely commit to staying. They further posit that job satisfaction is a precursor to commitment. It is difficult to separate commitment and satisfaction from each another as they are highly correlated. Mehrez & Al Bakri (2019) found that job satisfaction and commitment were connected and together they predicted staff's intention to stay. Ćulibrk et al. (2018) reported that organizational commitment "is an extension of job satisfaction as it deals with positive attitudes that an employee has towards their organization, and not their own role" (p. 4). This study's findings were consistent with prior research as job satisfaction had a greater impact on affective commitment than organization and task socialization. When testing the model for commitment, I used task and organization commitment as the independent variables and affective commitment as the dependent variable in one model and added job satisfaction to model two. The F change (21.356) in model one jumped to 40.035 in the second model signifying that job satisfaction greatly predicts commitment. This is extremely important for FFS organizations as leaders can work on ways to increase job satisfaction through addressing both intrinsic and extrinsic factors. This means addressing socialization practices, pay, and opportunities for advancement and promotion.

Impact of Organizational Socialization on Affective Commitment

Previous research on organizational socialization and commitment has been consistent in finding a relationship between onboarding strategies and commitment of staff (Bauer, 2010; Bauer et al., 2007; Carucci, 2018; Florentine, 2019; Van Maanen & Schien, 1979; Jones, 1986).

These studies suggest that when organizations dedicate proper time and resources into transitioning staff to their new positions, staff are more likely to engage and feel confident in performing their job functions. These positive attitudes allow employees to develop feelings of support and a sense of belonging towards the organization. These feelings often perpetuate loyalty, engagement, and commitment (Vance, 2006) In this study, the findings were mixed as the construct of organizational socialization had two components that included organization and task socialization. Task socialization referred to specific job training that allows workers to perform their duties. The survey included questions such as, *I know the responsibilities, tasks, and projects for which I was hired*, while organization socialization included on questions such as *I know the history of this organization (e.g., when and who founded the company, original services, how the organization survived through tough times).* When examining the variables individually (task and organization) and their individual relationship with affective commitment, the results revealed a significant relationship between organization socialization and affective commitment. The same was true with task socialization and its positive influence on affective commitment. However, when both organization and task (organizational socialization) were examined, the results were slightly different. Organization socialization was consistent with its previous finding of having a significant influence on commitment. When combined with organization socialization, task socialization, on the other hand, lost its effect and was not significant.

Meyer and Allen's (1997) affective commitment model can provide a logical explanation to the insignificant finding of organizational socialization (organization and task) of this study. Affective commitment is the development of positive feelings and attitudes towards one's organization that promotes. As discussed earlier, commitment is an extension of job satisfaction,

and it is achieved when staff feel a sense of belonging to their organization. When employees' socialization practices focus on providing tools, support and strategies to help them acclimated to the organization, they can develop confidence that helps with meeting the expectations of their position. This promotes feelings of satisfaction.

The results of the study showed that when task and organization variables were combined and tested, with affective commitment, task socialization lost its significance. One explanation can be that after the initial and the ongoing support staff receive to learn how to bill, manage their time, increase productivity, and decrease no shows, the need to continuously provide task socialization might not be as necessary to promote commitment. Instead, a greater focus on organization socialization can be the key to commitment. Knowing how to do a job well may not be enough to achieve commitment but identifying and being part of the organization: *I really feel as if this organization's problems are my own*, can achieve greater commitment. The results of the study supported and found significance for organization socialization when combined with task socialization. These results suggests that FFS administrators can benefit from understanding the role of organization socialization and task socialization and promote ongoing discussions between clinicians and supervisors to determine providing continued task socialization.

The results of this study revealed that most of the participants have achieved positive feelings about their position impacting their affective commitment. Although the overall outcome of the study revealed high levels of job satisfaction, there were several individuals who left anonymous, detailed negative messages of what their experiences were with their organization. The next section discusses the participant comments.

As discussed in chapter 3, of the 81 participants, six left additional comments. Four of the comments were negative, one was positive, and one response can be considered neutral "*I am n a*

second career where I still work full time in addition to part-time as an LGPC." This comment can be left for interpretation. One way to interpret this can be the assumption that the clinician is employed in a second part-position due to the inability to earn livable wages based on the estimated median salaries of mental health professionals. It can also be interpreted that the clinician enjoys the nature of work and is employed part time to further help people. One can also argue that individuals who are not satisfied with their employment or are contemplating leaving will more likely leave negative comments than those who are satisfied. However, these comments highlight the challenges of clinicians and mirrors reasons for this study about effective practices to promote commitment. For example, one participant reported "My agency has increased caseloads while threatening to modify pay schedule, while also withholding the Medicaid fee increases and ending contributions to our retirement." Herzberg's theory applies here unequivocally, as the participant addressed several of the hygiene factors such as reducing pay, fringe benefits, and poor work environment. This individual will not have loyalty towards an organization and, when the opportunity presents itself, the person will most likely voluntarily separate from his/her employment thereby contributing to the large turnover rate experienced by the industry.

Another participant stated, "My agency has increased caseloads while threatening to modify pay schedule while also withholding the Medicaid fee increases and ending contributions to our retirement. My onboarding experience was a couple of hours in Towson where several of the employees I was scheduled to meet with were out of the office (no notice given)." This statement illustrates the need to better understand organizational socialization including structure and timeframe. Another participant reported: "HR has been anything but helpful over the years when issues arose regarding pay discrepancies. We do not have PTO, paid holidays, etc. and are

not reimbursed for mileage (I'm an off-site therapist).” Another participant stated, “I was dissatisfied with the lack of training or even basic cultural awareness for my position. It was barely touched on.” A

These comments align with the challenges that FFS clinicians encounter on a regular basis. In addition to the stressors associated with working with individuals with high emotional needs, dealing with racial tensions, and within the chaos attributed to Covid-19, some FFS clinicians may worry about their decreased compensation, poor onboarding, lack of support, inadequate fringe benefits, and lack of compensation for essential time off. The challenges listed are the hygiene factors that decrease job satisfaction and can negatively impact commitment. The study’s results revealed that job satisfaction is a predictor of affective commitment, and if organizations are failing to provide these basic needs, the chances that staff will develop feelings of satisfaction much less commitment can be diminished. These additional comments can also be the basis for the developing the conceptual framework and the chose three theories underlying the study. Each comment aligns with either socialization theory or Herzberg’s motivation theory. They further explain the alignment within the conceptual framework that hypothesized the relationship between the constructs. These comments also highlight the need to further explore both the job satisfaction and commitment of FFS MH clinicians in future research to capture more detailed contextual meaning to the comments listed above.

Summary of the Study

The study examined relationships between organizational socialization (task and organization) and how it impacted job satisfaction and affective commitment of FFS MH clinicians. The literature review highlighted the positive relationships between these constructs

for both mental health and other fields within private and public sectors whether the position was salaried or based on commissions.

The transition to FFS positions is more challenging and cumbersome than beginning a new position in salaried settings. In FFS environments, new staff are trying to get acquainted to their new position while attempting to build their caseloads, manage their time, and learn strategies while providing billable therapeutic services. In the absence of effective organizational socialization, not much emphasis can be placed on learning, and providing billable services can become the priority. This can be detrimental to staffs' success as they may not have the opportunity to learn from others, get acquainted with their supervisors, or learn "tricks of the trade." Effective socialization includes teaching better scheduling strategies, providing realistic expectations, and creating initial opportunities to learn from others. Additionally, FFS clinicians' position does not require reporting to the office to provide services. The position is considered an offsite position, meaning that therapy takes place in clients' homes, schools, and different community locations. Therefore, the opportunity to learn from others has to be planned by the organization, as staff do not see each other and do not have the opportunity to learn from one another. Therefore, human resource personnel must create opportunities to provide structured, practical, and effective strategies such as time management and an organized approach to address no shows, non-compliance, and cancellations. Although these are skills and strategies that can be learned, there may be other factors that would contribute to clinician's inability to be successful within this model. Therefore, recommending better recruitment as part to talent management may be another area administrators can focus on. This position requires skills that go beyond the clinical skills learned during coursework. It requires time management skills, flexibility, ability to work independently, and entrepreneurship that may be not favored to clinicians who need

structure of a 9 to 5 work schedule in an office instead of creating their own schedules with flexible and sometimes unpredictable days. These are also opportunities for future research.

Limitations

This study was limited to a sample of FFS MH clinicians that were alums of graduate programs of two institutions and individuals who are on various social media platforms and professional groups. As a result, there was limited control as to who participated in the study. The welcome letter specified that the survey was for FFS MH clinicians working in Maryland.

This was a cross-sectional, non- experimental, self-reported study, and response bias (Althubaiti, 2016) may have impacted the way participants answered the questions. The results of the study are based on responses of 81 clinicians and may include biases that are not shared by other clinicians within the FFS field. Another limitation was the limited number of participants. The current impact of Covid -19 and the increased systematic social and racial injustice may have resulted in participants opting not to open the survey. Mental health clinicians were more impacted by the stay home orders while balancing childcare, family, while addressing the needs of their clients who may have been dealing with issues related to the pandemic. As a result, clinicians may have not been able to spare 15 minutes to complete the survey due to fatigue and stress related to the current events. Additionally, at the time social media platforms were flooded with misinformation (Pazzanese, 2020), and experts recommended taking breaks from social media. This may have also contributed to clinicians missing the opportunity to complete the study. Another limitation may have been the demographic composition of the sample. The majority of the participants were White and only four participants identified as being Black. The lack of responses by clinicians who were Black may have been the result of the intensified

violence and the murder of George Floyd that increased depression and anxiety (Fowers & Wan, 2020). Public distrust increased, and many Black Americans sought treatment from Black therapists which resulted in increased caseloads (Gaines, 2021).

Social desirability is another bias that often can affect responses as individuals may answer based on what is acceptable instead of their true feelings (Meisters et al., 2020). Another limitation of the study is recall bias that often relies on participants recalling previous experiences of their socialization practices. 26 participants reported being in their organization between 3-5 years their reflection about prior experiences may not be accurate and they can either overestimate or underestimate their experiences (Althubaiti, 2016). A total of 37 people reported working for less than two years and how they feel about the organization may have impacted their responses. A final bias results from the quantitative nature of the study that may introduce a limitation as it cannot offer contextual understanding of the complexity of organizational socialization, job satisfaction, or commitment.

Discussion Summary

The study's intention is to help FFS leaders to implement organization socialization to increase satisfaction and improve commitment of MH clinicians within outpatient clinics. The study also sought to understand common job satisfaction factors to determine areas that leaders can focus on to increase job satisfaction.

Implication and Future Direction

This study offered introductory information on organizational (organization, task) socialization and their influence on job satisfaction and affective commitment for FFS MH clinicians. The study further highlighted findings from previous research that identified important job satisfaction factors for clinicians working in salaried positions. An implication

from the findings of this study is the potential for FFS MH clinicians to obtain better salaries than what is reported nationally by the Bureau of Labor Statistics (2019, 2020). The study can potentially change attitudes about the income clinicians can make within the field. Yet the sample was too small to draw any conclusions. Due to the small sample size this topic on income needs to be explored more. Future similar findings can defy the stigma such as earning low wages, high stress, and having large caseloads associated with the field. For example, it is a long-standing notion that individuals choosing the mental health profession focus on helping instead of deriving six figure salaries. The National Association of Social Workers (NASW) reports that "Social workers are people who care about people, who want to make things better, who want to relieve suffering, and who want their work to make a difference" (Why Choose the Social Work Profession? (Para.1). Other articles point out nobility of the profession, but very little is done to elevate the profession to equalize it with other occupations with comparable employees (Lewis, 2018). This perspective has limited clinicians' financial growth and solidified this longstanding stigma of earning low wages. The salary range for the field has fallen short when compared to other disciplines with less education (BLS, 2016, 2020). This attitude needs to change, and this study has offered preliminary data supporting the potential of earning better salaries. Additionally, the limited evidence provided by the 81 participants suggests that when organizations provide socialization practices early on, job satisfaction can increase. These efforts will potentially drive individual and organizational productivity.

Another implication from this study is understanding the role of onboarding and its relationship with job satisfaction and commitment. First, to improve retention, leaders may promise high salaries, flexibility, and autonomy to have candidates excited about taking the position, but the initial excitement, when not then supported with the appropriate training and

socialization activities, may leave clinicians feeling frustrated. Second, assessing existing socialization practices and identifying areas of improvements will allow leaders to evaluate their own practices. Finally, being open to the implementing evidence-based strategies and looking for practical ways to improving organizational socialization can assist in to increasing job satisfaction.

Another implication of the study is an understanding of the role of promotional opportunities to achieve high levels of job satisfaction and commitment. In this study, participants identified promotion as one of the lowest ranked of the nine facets of the JSS survey. This information can help administrators to create promotional opportunities for career advancements. Over 50% of the sample were clinicians who had advanced licensure in social work and counseling and who can acquire certification to become clinical supervisors. Leaders can offer supervisory roles to eligible clinicians looking for opportunities for advancement while potentially achieving retention and a culture of advocating for clinician growth. Lastly, FFS leaders can benefit from a mindset that individual clinician productivity (meeting the requirements of the position and achieving the required minimum monthly billings) can contribute to organizational productivity. When clinicians are satisfied and committed to the organization, it is more likely that they will refer their friends and family to seek employment within the organization, thus increasing organizational productivity. When administrators provide guidance, resources, and organizational socialization, they are investing not just in their clinicians' future but also that of the organization. Supporting clinicians' goals to have a workplace that provides clear communication, fair polices, and adequate pay can increase job satisfaction.

The results of this study found statistically significant relationships between level of job satisfaction and commitment suggesting that staff who have a high level of job satisfaction tend to be more committed. Organizations' greatest asset is their human capital, and by investing in their clinicians they are investing towards the future of the organization.

The results that this study offered can be the starting point for future research. Due to the circumstances of Covid-19 and the systematic racism and increased social tensions, conducting the same research post Covid-19 and comparing the results with the current study's results to draw correlations between the two would provide meaningful data to see how context may influence findings. Additional research can include a qualitative study to interview FFS clinicians to add context and deeper meaning about the role of socialization practices and their potential relationship with job satisfaction and affective commitment. These interviews will provide an in-depth insight, opinions, and experiences of FFS clinicians and capture their attitudes. Future research can also examine individual demographic variables, such as age and race, and their role related to job satisfaction and commitment. Also, additional areas of research could explore individual job satisfaction variables as predictors to commitment and highlighting which variables have the strongest associations. Conducting research to explore socialization practices within different organizations and their retentions rates is also needed. Further research can explore the importance of personality traits in predicting person and job fit to determine the alignment between individuals and the functions they will perform at work. Mental health clinicians can work in a variety of settings and an OMHC is one of the many possible possibilities. This position can be a great fit for individuals who can work independently, are entrepreneurs, enjoy driving, and meeting clients where they are instead of offering services in an office. There is a percentage of clinicians for whom the position may not be a good fit, and

this model of compensation and environment may not be right for those who seek consistent compensation package. Some clinicians like structure, routine, and the familiarity of an office, instead of working remotely and driving to different locations. Additional research can focus on examining recruitment and hiring policies within different organizations' HR departments in managing talent and find themes that industry leaders can learn and benefit from to improve retention.

Finally, additional research is needed to examining curriculum offered in graduate programs for social work and counseling to explore what skills are needed for success in private practice and OMHC. In both settings, compensation is based on the number of billable services rendered. Institutions of higher education that offer graduate course work can benefit from hearing the challenges of new graduate clinicians to better prepare them to be successful. As new clinicians trying to find their niche, they are looking for positions with appropriate wages, flexibility, and autonomy. If they are not taught the business skills needed to manage the challenges of the position, they are left feeling frustrated and finding traditional salaried positions that potentially require longer hours and greater caseloads that often lead to burnout and poor job satisfaction. Existing research has found positive relationships between poor job satisfaction and high turnover. Therefore, there is an opportunity to prepare students while they are receiving their education. This can be achieved through a partnership between schools and various OMHCs to prepare students for the workforce. These partnerships are often in the form of agreements between graduate schools and OMHCs to accept students for internship. In addition to helping newly graduates learn the skills, this collaboration also creates a pipeline to mentor, graduate students, teach them, train them, and offer them employment opportunities.

As the CEO of an outpatient mental health clinic, the findings of this will have a practical implication on the operations of the organization's socialization practice (onboarding). Starting with training the human resources personnel, clinical supervisors, and directors and highlighting the importance of job satisfaction factors and the role of organization and task socialization on job satisfaction and staff commitment. Implementing new onboarding strategies supported by theory and backed by research can offer insight to the needs of new and existing employees and can save organizations costly turnovers. Including business management lectures to the organizational socialization process and teaching business acumen may help clinicians effectively manage their time and caseloads. As an administrator, I have seen first-hand the effects of poor onboarding on staff morale, lack of productivity, loss of revenue and clients, frustration, and voluntary separation of employment. Another practical implication is the need to look at strategies to increase motivation and decrease hygiene factors. As discussed in previous chapters, a few of the motivation factors include valuing staff, supporting them, and providing opportunities for advancement. Additionally, understanding that hygiene factors such as policies, will always be present and cannot be eliminated, but the focus of administrators needs to be on increasing motivations factors as decreasing hygiene factors do not increase motivation. Another practical implication is the opportunity of workshops to train business leaders in effective way of onboarding in the FFS MH industry,

Afterword

Completing this research during the pandemic while running a midsize organization with five sites was challenging. As a social worker and organizational leader, I was tasked with ensuring that clients' needs were being met along with clinicians and staff who were extremely overwhelmed. When the Governor declared a state of emergency in Maryland as and allowed

Telehealth, the clinic suspended all in-person operations except for those in the corporate office. We were proactive in acquiring software to offer services virtually. In a fortnight, we set up staff with individual HIPPA compliant licenses to continue services without any disruption. During the first two weeks, clinicians were challenged with being able to put their own needs aside to focus on clients. The executive team conducted town hall meetings and reminded staff of our moral obligation to help clients who had no transportation, limited resources, and in potentially unhealthy environments. Authenticity, transparency, support, and honesty allowed the clinic to remain operational to meet the needs of the mentally illness. As the pandemic continued the caseloads went up and both staff and clients' wellbeing and mental health declined. We saw the toll it took on staff and noticed the complexities of the virtual world and the heavy reliance on technology. Human resources saw an influx in getting accommodations for reduced work schedules, caseload sizes, and leave of absence requests. The executive team made accommodations to support staff as best as possible while tending to the needs of the clients. Clients' needs went from needing mental health services to requesting technical assistance with technology. The clinic deployed staff to offer guidance to provide clients the ability to meet their clinicians. Over time, compliance decreased as many clients, especially children and adolescents, were not able to engage in the virtual sessions. Staff were encouraged to offer frequent brief sessions instead of full sessions. Prioritizing cases to meet the demands of the communities increased referrals while managing the requests for staff accommodations.

While dealing with the issues related to Covid -19, June 2020, brought on new challenges associated with racism. Although racism is not a new issue, the year 2020 magnified the racial tensions and intensified the violence towards Black community members. The country was polarized, and violence became an ongoing challenge impacting the wellbeing of families. This

very important issue became identified as the second pandemic (Addo, 2020). The executive team was immediately provided trainers to educate staff about diversity, inclusion, and equality. Offering support and dialogue in addition to renaming the cultural competence committee to DEI (Diversity, Inclusion and Equity) were ways of supporting staff. Despite these efforts, some staff felt the clinic did not do enough to support them. Human resources deployed a survey to gather information about ways to support staff. Most suggestions were geared towards increased training and raising awareness.

During the past year and a half, balancing work, school, family life, and the increased demands running the clinic have put things in perspective. My passion to support clinicians and clients has allowed me as a leader to provide the best for my staff. I have listened to their stories of losing clients and family members, their struggles creating work-life balance and acknowledging that there was no quick answer, have shaped my leadership and resilience. As we move towards a new normal, I have learned that being empathetic and supportive to the staff, being decisive, moving forward, and with strategic thinking have allowed the clinic to remain open and operational. True to Herzberg's theory of motivation to ensuring that staff felt valued, listened to, cherished and supported became everyday discussions with staff.

As the economy is trying to recover and staff find themselves exhausted, we are seeing a wave of new challenges that mental health organizations are dealing with due to compassion fatigue. Increasing job satisfaction and commitment as clinics are getting ready to return to in-person sessions is the topic of ongoing discussion for leaders making this study all the more relevant. Additionally, returning back to in-person sessions has left many clinicians worried as COVID-19 continues to spread. This has them looking for opportunities to continue to work remotely. This is expected to create a new shortage of clinics offering in-person sessions

compared to virtual sessions. Once again, leaders have to get creative to balance the need of clients with keeping clinical staff motivated, satisfied, and committed.

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APPENDIX A

INSTITUTIONAL REVIEW BOARD APPLICATION AND APPROVAL LETTER

Hood College
Institutional Review Board
Research Proposal

1. **Title of Proposal**: The Impact of Organizational Socialization on Job Satisfaction and Commitment of mental health clinicians within the Fee-for-Service organizations.
2. **Principal Investigator (PI):** Vera Kurdian
3. **PI Department:** Doctoral Program in Organizational Leadership
4. **PI Contact Information**: **Vera Kurdian, 240 447 7777**
   Vkurdian@abhmaryland.com
5. **Faculty Sponsor and Contact Information): Kathleen Bands Ph.D., Professor of Education and Program Director, DOL program** Bands@hood.edu**;**

6. **Other Investigators**: **Dissertation Committee Members:**

   Lisa Littlefield, Ph.D.
   Dean, Center for Career Development and Experiential Education
   Hood College
   Megan J. D. Shaine, Ph.D.
   Assistant Professor of Psychology and Counseling
   Practicum and Internship Coordinator
   Department of Psychology and Counseling
   Hood College
7. **Date of this Submission: January 21, 2021**

8. **Proposed Duration of the Project**): February 2021 February 2022

9. **Background Information and Research Questions/Hypotheses**:
   The purpose of this study is to explore whether organizational socialization (onboarding) has any influence on job satisfaction and commitment of mental health clinicians working within the Fee for service (FFS) industry. Recruiting, hiring, organizational socialization (task socialization and organization socialization), and retaining clinicians are high priorities for organizations that want to meet the mental health needs of individuals of all ages. Increasing job satisfaction and commitment is important as organizations are competing to hire and retain staff. One method to increase job satisfaction and commitment is through effective organizational socialization (onboarding) of new employees. Another method is to understand the needs of existing employees to increase retention. With the initial Covid-19 pandemic and the second pandemic of racial and social injustice, now more than ever the field of mental health requires trained clinicians to address the needs of individuals suffering from mental health illness.

   I have been a social worker for over 18 years working in a variety of clinical., academia, and training settings. Currently, I am the CEO of an outpatient mental

health clinic that compensates staff based on FFS (Fee for Service) model. My experience within the field and passion to improve the lives of mental health clinicians have led me to this study and guided the following research questions:

1. What are the job satisfaction factors for clinicians operating in FFS organizations?
2. Does Organizational Socialization impact job satisfaction and commitment of FFS clinicians?

*Organizational Socialization is identified as:
1) Organization socialization (policies, procedures, orientation), and
2) Task Socialization (Job specific skills).

My Hypotheses are:

H1: Organizational socialization (polices, procedures, orientation) is positively related to job satisfaction for FFS clinicians

H2: Task Socialization positively impacts job satisfaction for FFS clinicians

H3: Organizational socialization positively impacts commitment of FFS clinicians.

Note: All hypotheses are related to the second research question.

10. Human Participants:

A. Who are the participants?

Commission based licensed Maryland mental health clinicians working within FFS organizations. Participants will hold any of the following licenses: LMSW, LCSW-C. LGPCS, LCPC and LMFT. Additionally, several of my colleagues in the field have indicated that they will extend the invitation to clinicians working within the Fee-for-Service industry.

B. How many participants do you plan to have in your study?

Based on the sample size calculator, with 15 predictors, the survey seeks to have 123 or more participants.

C. How will the participants be contacted or recruited?

Respondents will be recruited through social media platforms as well as through two universities with Counseling and Social work programs alumnae database. The welcome letter and the link will be posted on social media (Facebook and LinkedIn). The same welcome letter and the link will be shared with the faculty of the two Institutions of Higher Education (IHE) in Maryland. The invitations will contain a link to the online survey.

D. Will the participants be compensated for participating? If so, describe

Although there is no direct compensation, participants will have the opportunity to win a $100 Amazon gift card through a raffle drawing. If participants choose to enter the drawing, they can either share their email address. To be eligible, participants must finish the survey and choose to either agree or opt out to enter the drawing.

Please see attached emails of support to share the survey with alumnae listserv. Additionally, I received verbal agreement from one of the Programs to share the survey link with the alumnae as well.

11. **Procedures**: The survey will be hosted on SurveyMonkey. A copy of the survey instrument is attached. The procedure is as follows:

- Potential participants will be invited by email, Facebook and LinkedIn. The invitation will be shared with the faculty who will send the welcome letter and the survey link to their respective listserv. Additionally, the welcome letter will be posted on both LinkedIn and Facebook-social media platforms. The invitation will include the welcome letter (attached), and the link to the survey on SurveyMonkey.
- Once the survey is opened, participants will be presented with the same welcome letter as well as the informed consent notice. After reading the welcome and consent notification, participants will then be asked if they wish to participate. A response of "yes" will allow the survey to continue, while a response of "no" will end the survey.
- A 30-day timeline will be set with weekly posting on social media platform and respectfully requesting faculty from participating universities to send reminder emails. Participants can complete the survey at their leisure in their preferred environment. Participants can skip questions, and/or end the survey at any time.
- Participants will be given the opportunity to enter a raffle drawing to win a $100 Amazon gift card. The following will be made clear: (1) entering the drawing is optional and they can do so by leaving their email address, (2) should they choose to do so, it will remain confidential., and (3) it will only be used to contact the winner. The email will be independent of their responses. I will not be able to associate their answers to their emails.
- Survey responses will be downloaded and processed offline using IBM SPSS software packages

12. **Consent:**

I am requesting a waiver for the written consent as the survey and recruitment letter will be posted electronically and shared with the college and university that have given me permission. After interested individuals read the recruitment announcement and want to participate, they will be asked if they agree with the informed consent notice. If participants agree they will continue with the survey. Should they not agree, the survey will end.

13. **Risks and Debriefing:**

There are no anticipated concerns about participants being harmed or placed at risk. One potential risk associated with online surveys is participant frustration with multiple communications about survey completion. Debriefing is optional and it will be in the form of receiving highlights of the survey. The results of the survey will be used solely for this dissertation and will be published in aggregate form

14. **Privacy and Storage of Data**:

Data will be collected electronically and anonymously on SurveyMonkey software. The IP address will be disabled in SurveyMonkey to protect the anonymity of

participants. The only individuals who will be given access to the raw data will be the principal investigator and members of the committee. Any correspondence can be sent to a generic email address, and no one other than the principal researcher will have the password for the email address.

HOOD COLLEGE
GRADUATE SCHOOL
DOCTORAL PROGRAM IN ORGANIZATIONAL LEADERSHIP

February 8, 2021

Ms. Vera Kurdian
401 Rosemont Ave.
Frederick, MD 21701
Dear Ms. Kurdian,
The Hood College Institutional Review Board reviewed your revised proposal for the study entitled *"The Impact of Organizational Socialization on Job Satisfaction and Commitment of mental health clinicians within the Fee-for-Service organizations."* (Proposal Number 2021-17). The committee determined that this study merits EXEMPT status and approves this study for a period of 12 months. This approval is limited to the activities described in the procedure narrative and extends to the performance of these activities at each respective site identified in the IRB research proposal. This approval does not authorize you to recruit participants or conduct your study on site at other institutions. Should you decide, you would like to systematically recruit participants and/or conduct your study on location at other institutions or facilities you will need to receive IRB approval from those organizations *prior* to any recruitment activities or data collection.

In addition, due to the current COVID 19 precautions, Hood's IRB is restricting all in-person (e.g., face-to-face) data collection with participants currently. You may only recruit participants and collect data online. You are not authorized to meet with your participants for the purpose of data collection until notice from this IRB. In accordance with this approval., the specific conditions for the conduct of this research and informed consent from participants must be obtained as indicated.

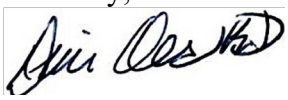
All individuals engaged in human subjects research are responsible for compliance with all applicable Hood Research Policies: *https://www.hood.edu/sites/default/files/Hood%20IRB%20Policy%20revised%20September%202013.pdf*.

The Lead Researcher of the study is ultimately responsible for assuring all study team members review and adhere to applicable policies for the conduct of human sciences research.

The Hood College IRB approval expiration date is January 8th, 2022. As a courtesy, approximately 30-60 days prior to expiration of this approval., it is your responsibility to apply for continuing review and receive continuing approval for the duration of the study as applicable. Lapses in approval should be avoided to protect the safety and welfare of enrolled participants.

No substantive changes are to be made to the approved protocol or the approved consent and assent forms without the prior review and approval of the Hood IRB. All substantive changes (e.g. change in procedure, number of subjects, personnel, study locations, study instruments, etc.) must be prospectively reviewed and approved by the IRB before they are implemented.

Sincerely,



Diane R. Graves, PhD
Chair, Hood College Institutional Review Board

APPENDIX B

WELCOME LETTER AND CONSENT FORM

Welcome!

Date
Dear Colleague,

My name is Vera Kurdian, and I am a doctoral candidate at Hood College in Frederick, Maryland seeking a degree in Organizational leadership. In addition to being a doctoral candidate, I am a social worker and work within the Fee-for-Service (FFS) Outpatient Mental Health Clinics (OMHC). I have been practicing social work in a variety of settings including child welfare, private practice, hospital work and most recently in an OMHC. I am extremely interested in enriching the lives of mental health clinicians and passionate about improving clinicians' work environment, job satisfaction and how they are onboarded within FFs OMHCS. This passion has guided my current topic and the interest in seeking higher education.

My study is related to mental health providers working in outpatient mental health clinics and getting a percentage of their billings. My research title is: The Impact of Organizational Socialization (onboarding) on Job Satisfaction and Organizational Commitment. It will also measure factors influencing job satisfaction for clinicians working within the FFS organizations. This research is for graduate level clinicians possessing licenses to include LMSW, LCSW-C, LCPC, LGPC and LMFT and working within Fee-for-Service Outpatient Mental Health Clinics (OMHC).

I am inviting you to participate in this research study by completing an online survey through SurveyMonkey. This online survey will take about 20-25 minutes and it will be anonymous. No identifying information will be asked of you. There are no risks associated with this survey and participation is strictly voluntary. You may stop the survey at any time.
Thank you for taking the time to assist me in my educational endeavors. The data collected will provide useful information to leaders to examine their onboarding practices and look for ways to increase job satisfaction and commitment.

Upon the completion of this survey, you will be eligible for a drawing to win a $100 Amazon gift card.

If you require additional information or have questions, please contact me via email, phone, inbox me through messenger and LinkedIn
Sincerely,
Vera Kurdian, LCSW_

Informed Consent

Thank you again for considering participation in the online survey. The purpose of this study is to explore the impact organizational socialization /onboarding on job satisfaction and commitment of clinicians working within the FFS. It will also measure job satisfaction factor that contribute to increasing commitment. Your responses will help inform leaders within the field and contribute to developing new knowledge about mental health clinicians.
Your participation is voluntary, and no personal information will be asked of you, and you may stop anytime. You are not being forced /coerced to take part in this survey. There are 84 questions, and you can skip any questions you choose not to answer. There are no known risks to participating in this survey.

The procedure involves completing an online survey that will take about 20-25 minutes to complete. Your responses are confidential and no identifying information will be asked of you. The data will be stored in a password protected file accessible only by the researcher. The results of this study will be published in an aggregated form and no individual participant can be identified.

If you wish to be included in a raffle to win a $100 Amazon gift card, please feel free to either send me an email or a phone number so I may contact you should you win the raffle. You may decline to be included for the raffle.
By responding “yes” you indicate that:

- You have read and fully understand the above information
- You possess license of LMSW, LCSW_C, LGPC, LCPC, or LMFT
- You are voluntarily agreeing to participate

Link will be inserted here

APPENDIX C

SURVEY QUESTIONS

The Role of Organizational Socialization on Job Satisfaction and Commitment

SECTION ONE: DEMOGRAPHIC INFORMATION
Please answer the following questions so that I know more about you.
This confidential information is very important for ensuring good analysis.

1. What is your age/generation?	(Check one)
24-34	
35-45	
56-56	
56+	
Prefer not to answer	

2. What is your gender?	(Check one)
Female	
Male	
Other	
Prefer not to answer	

3. **What type of license do you currently possess?**	(Check one)
Licensed Master Social Worker (LMSW)	
Licensed Clinical Social Worker (LCSW)	
Licensed Graduate Professional Counselor (LGPC)	
Licensed Clinical Professional Counselor (LCPC)	
Licensed Marriage and Family Therapist (LMFT)	

4. **What is your race/ethnicity?**	(Check one)
White	
Black/African American	
Hispanic/Latino/Latina	
Asian or Asian American	
Two or more races	
American Indian and Alaska Native	
Native Hawaiian and Other Pacific Islander	
Prefer not to answer	

5. **What is your salary range?**	(Check one)
25k to 50k	
51k-65K	

66k- 75k	
Over 75k	
Other (please specify)	
Prefer not to answer	

6. **Do you live on one income or two income household?**	(Check one)
One income	
Two income	
Other	
Prefer not to answer	
None of the above	

7. **Prior to working for your current organization, did you have any prior experience working within the FFS organizations or clinics?**	(Check one)
Yes	
No	

8. **How long have you worked in your current profession?**	(Check one)
2 years or less	
3 to 5 years	
6 to 10 years	
11 to 15 years	
16 or more years	

9. **How long have you worked in your organization/clinic?**	(Check one)
2 years or less	
3 to 5 years	
6 to 10 years	
11 to 15 years	
16 or more years	

10. **When you were hired, did you receive any socialization/onboarding skills beyond the orientation?**	(Check one)
Yes	
No	
Prefer not to answer	

11. **How long was your socialization/onboarding experience?**	(Check one)
1-7 days	
8-15 days	
16-22 days	
23-30 days	
Over a month	

12. **What were the specific socialization skills that you received?**	(Check one)
HR Orientation (benefits, Company policies, mission vision)	
HR Orientation, Introduction of Key individuals, History of comp	
HR Orientation, Introduction, Company culture, history and culture	
HR Orientation, Introduction, history, comp culture, time Moment training, where to seek help, strategies for success	
None of the above	
Prefer not to answer	
13. How soon after your hire date did you receive your first case?	(Check one)
1-7 days	
8-15 days	
16-22 days	
23-30 days	
Over a month	
14. Were you compensated for the time you spent in onboarding?	(Check one)
Yes	
No	
Prefer not to answer	
15. Did your organization address the social injustice within your organization to your satisfaction?	(Check one)
Yes	
No	
Prefer not to answer	
16. Do you think your organization handled the pandemic to your satisfaction?	(Check one)
Yes	
No	
Prefer not to answer	
17. Optional: What County are you employed in?	(Check one)
Yes	
No	
Prefer not to answer	
18: Additional Comments	

SECTION TWO: ORGANIZATIONAL SOCIALIZATION Haueter et al. (2003)		
	SECTION 2.1 **ORGANIZATION SOCIALIZATION**	Items are presented in the order listed A 7-point Likert-type response format (1 = strongly disagree to 7=strongly agree) is used. Please circle one of the This form of socialization is **(circle one):**
		1 Strongly disagree 2 Disagree 3 Somewhat disagree 4 Neither agree nor disagree 5 Somewhat agree 6 Agree 7 Strongly agree
1	I know the specific names of the products/services produced/provided by this organization.	1234567
2	I know the history of this organization (e.g., when and who founded the company, original products/services, how the organization survived tough times).	1234567
3	I know the structure of the organization (e.g., how the departments fit together). Support in addressing employees' personal needs	1234567
4	I understand the operations of this organization (e.g., who does what, how sites, subsidiaries and/or branches contribute).	1234567
5	I understand this organizations objectives and goals.	1234567
6	I understand how various departments, subsidiaries, and/or sites contribute to this organization's goals.	1234567
7	I understand how my job contributes to the larger organization.	1234567
8	I understand how to act to fit in with what the organization values and believes.	1234567
9	I know this organizations overall policies and/or rules (e.g., compensation, dress code, smoking, travel expense limitations).	1234567
1 0	I understand the internal politics within this organization (e.g., chain of command, who is influential., what needs to be done to advance or maintain good standing)	1234567
11	I understand the general management style (e.g., top-down, participative) used in this organization	1234567
12	I understand what is meant when members use language (e.g., acronyms, abbreviations, nicknames) particular to this organization, jargon)	1234567

	Section 2.2 TASK SOCIALIZATION	
1	I know the responsibilities, tasks and projects for which I was hired.	1234567
2	I understand how to perform the tasks that make up my job.	1234567
3	I understand which job tasks and responsibilities have priority	1234567
4	I understand how to operate the tools I use in my job (software, voicemail and programs)	1234567
5	I know how to acquire resources needed to perform my job (e.g., authorizations, CPT codes, Insurance rules time management).	1234567
6	I know who to ask for support when my job requires it	1234567
7	I know who my customers (internal and external) are.	1234567
8	I know how to meet my customer's needs	1234567
9	I know when to inform my supervisor about my work (e.g., daily, weekly, close to deadlines, when a request is made).	1234567
10	I know what constitutes acceptable job performance (i.e., what does my supervisor and/or customers expect of me, number of sessions)	1234567
11	In the course of performing my job, I understand how to complete necessary forms/paperwork (e.g., time timely clinical notes).	1234567

	Section Three: JOB SATISFACTION SURVEY Paul E. Spector Copyright Paul E. Spector 1994, All rights reserved.	
	PLEASE CIRCLE THE ONE NUMBER FOR EACH QUESTION THAT COMES CLOSEST TO REFLECTING YOUR OPINION ABOUT IT.	Disagree very much Disagree moderately Disagree slightly Agree slightly
1	I feel I am being paid a fair amount for the work I do.	123456
2	There is really too little chance for promotion on my job.	123456
3	My supervisor is quite competent in doing his/her job.	123456
4	I am not satisfied with the benefits I receive.	123456
5	When I do a good job, I receive the recognition for it that I should receive.	123456
6	Many of our rules and procedures make doing a good job difficult.	123456
7	I like the people I work with.	123456
8	I sometimes feel my job is meaningless.	123456
9	Communications seem good within this organization.	123456
10	Raises are too few and far between.	123456
11	Those who do well on the job stand a fair chance of being promoted.	123456
12	My supervisor is unfair to me.	123456
13	The benefits we receive are as good as most other organizations offer.	123456
14	I do not feel that the work I do is appreciated.	123456
15	My efforts to do a good job are seldom blocked by red tape.	123456
16	I find I have to work harder at my job because of the incompetence of people I work with.	123456
17	I like doing the things I do at work.	123456
18	The goals of this organization are not clear to me.	123456

	PLEASE CIRCLE THE ONE NUMBER FOR EACH QUESTION THAT COMES CLOSEST TO REFLECTING YOUR OPINION ABOUT IT. 	Disagree very much Disagree moderately Disagree slightly Agree slightly Agree moderately Agree very much
19	I feel unappreciated by the organization when I think about what they pay me.	123456
20	People get ahead as fast here as they do in other places.	123456
21	My supervisor shows too little interest in the feelings of subordinates.	123456
22	The benefit package we have is equitable.	123456
23	There are few rewards for those who work here.	123456
24	I have too much to do at work.	123456
25	I enjoy my coworkers.	123456
26	I often feel that I do not know what is going on with the organization.	123456
27	I feel a sense of pride in doing my job.	123456
28	I feel satisfied with my chances for salary increases.	123456
29	There are benefits we do not have which we should have.	123456
30	I like my supervisor.	123456
31	I have too much paperwork.	123456
32	I don't feel my efforts are rewarded the way they should be.	123456
33	I am satisfied with my chances for promotion.	123456
34	There is too much bickering and fighting at work.	123456
35	My job is enjoyable.	123456
36	Work assignments are not fully explained.	123456

SECTION FOUR: ORGANIZATIONAL COMMITMENT Meyer and Allen Revised 1993		
	Affective Commitment	Items are presented in the order listed A 7-point Likert-type response format (1 = strongly disagree to 7=strongly agree) is used. Please circle one of the This form of socialization is **(circle one):**
		1 Strongly disagree 2 Disagree . 3 Somewhat disagree . 4 Neither agree nor disagree . 5 Somewhat agree . 6 Agree . 7 Strongly agree
1	I would be very happy to spend the rest of my career with this organization.	1234567
2	I really feel as if this organization's problems are my own	1234567
3	I do not feel a strong sense of "belonging" to my organization	1234567
4	I do not feel "emotionally attached" to this organization	1234567
5	I do not feel like "part of the family" at my organization.	1234567
6	I understand how various departments, subsidiaries, and/or sites contribute to this organization's goals.	1234567
7	This organization has a great deal of personal meaning for me.	1234567

APPENDIX D

PERMISSIONS

Permission to Conduct the Pilot Study

Vera Kurdian <VKurdian@abhmaryland.com>
Thu 9/24/2020 3:37 PM
To: Steve <sgassoc@comcast.net>; Karen RoppKRopp@abhmaryland.com

Good afternoon Karen and Steve,

As you both are aware, I am currently enrolled in the doctoral program for organizational leadership at Hood College. My research study will explore the relationships between organizational socialization, job satisfaction and commitment of clinicians within the FFS OMHCs. It also seeks to measure job satisfaction factors that influence commitment.

The results of this study will benefit leaders and will allow them to make necessary changes to their onboarding practices to increase retention. It will further help organizations understand factors that would increase clinicians job satisfaction. Current literature supports the phenomena that job satisfaction increases commitment. Understanding the needs of staff will also allow organizations to offer relevant benefits and incentives to their staff.

I am reaching out to seek your permission to conduct my pilot study with ABH clinicians. The survey will be anonymous, and it should not take more than 15-20 min. The purpose of this pilot is to ensure the instruments that I am using answer my research questions. It will also allow me to refine my questions (if needed) prior to the actual study.

My plan is to send the research link to staff along with the recruitment letter. It will be voluntary and no personal information will be required. Participants can stop the survey anytime.

Thank you for your consideration and ongoing support of my academic endeavors and growth. I look forward to hearing from you.

Respectfully,

Vera Kurdian, LCSW-C
CEO
Program Director
Board Certified Supervisor
Advanced Behavioral Health, Inc
Advanced Counseling Services
T: 301 345 1022 Ext 7015
F: 301 560 5558

Re: Permission to Conduct the Pilot Study
Steve <sgassoc@comcast.net>
Thu 9/24/2020 3:41 PM
To: Vera Kurdian <VKurdian@abhmaryland.com>
Proceed.
Stephen Green, LCPC
Co-Founder, President,
Advanced Behavioral Health
ABHmaryland.com
301/873/5363
Re: Permission
Karen Ropp <KRopp@abhmaryland.com>
Thu 9/24/2020 3:50 PM
To: Vera Kurdian <VKurdian@abhmaryland.com>
Cc: Steve <sgassoc@comcast.net>
You have our permission to move forward
Good luck!!!
Karen Ropp, LCSW-C
Owner
ABH
301-748-4712

From: Vera Kurdian <VKurdian@abhmaryland.com>
Sent: June-25-20 9:12 PM
To: John Peter Meyer <meyer@uwo.ca>
Subject: TCM
Good evening Dr. Meyer,

I hope this email finds you well.

I am a doctoral student at Hood College located in Frederick, MD working towards a degree in Organizational Leadership. Currently, I am working on submitting my proposal. My topic is: The Impact of Organizational Socialization on Organizational Commitment and Intent to Stay, mediated by Job Satisfaction with Mental health Providers Working in a Fee-for-Service Clinic. I am contacting you to seek permission to use the commitment model questionnaire. Please let me know if you have a formal process to submit approval requests. I look forward to hearing from you.

Respectfully,

Vera Kurdian, LCSW-C

Permission for the Use of TCM Questionnaire

From: John Peter Meyer <meyer@uwo.ca>
Sent: Friday, June 26, 2020, 6:13:29 AM
To: Vera Kurdian <VKurdian@abhmaryland.com>
Subject: RE: TCM
Hello Vera,

Thank you for your interest in using the Three-Component Model (TCM) Employee Commitment Survey in your research. You can get information about the measure, a Users' Guide, and the measure itself at:

http://employeecommitment.com/

For academic / research purposes, please choose the Academic Package (There is no charge for this package.)

I wish you well with your research!

Best regards,

John Meyer

Request to Share Survey Link with Alumni

06/23/2020
Dear Ms. Chibani,

I am a Doctoral Candidate at Hood College and in the process of seeking proposal approval for my research study. The study will look at *The Impact of Onboarding Practices on Job Satisfaction and Commitment for Clinicians Working Within the Fee for serviceClinics*. Would it be possible for you to share my research interest with alumni working in different mental health clinics? The study will be in the form of a survey questionnaire and will be confidential. There will be no risks associated with the survey and participants will be eligible to win a $100 Amazon gift card from a drawing.

Thank you!

Respectfully,

Vera Kurdian LCSW-C
Doctoral Candidate 2021
Hood College

From: Doha Chibani<chibani1@umbc.edu>
Sent: Saturday, June 27, 2020, 1:46 PM
To: Vera Kurdian <VKurdian@abhmaryland.com>
Subject: Re: Thanks for the call today

Dear Vera,

Thank you for reaching out and sharing information about your study investigating The Impact of Onboarding Practices on Job Satisfaction and Commitment for Clinicians Working Within the Fee for serviceClinics.

I would be delighted to share your survey link with the Strive for Wellness continuing education listserv of clinicians across the state of Maryland. I am also able to send it through the UMBC Counseling Center Referral Service Database and will be posting it to the social media site for Mental Health Practitioners of Baltimore/Washington Metro Area. This will give you access to over 2500 clinicians in the state of Maryland.

I hope this will be of help and wish you the best in your endeavor.

Sincerely,

Doha

Doha Chibani, LCSW-C
Pronouns: she /her /hers
Clinical Coordinator
UMBC Psychology Department
Strive for Wellness Clinic & *Youth FIRST Lab*
Ph: 410-206-7415
For referrals to our services please use this link: https://is.gd/StriveScreen

Response to Request to Share Survey Link
From: Gricus, Michelle <gricus@hood.edu>
Sent: Wednesday, June 24, 2020, 2:09 PM
To: Vera Kurdian <VKurdian@abhmaryland.com>
Subject: Re: Research

Vera,

Hello! Thank you for reaching out to Malikah regarding your research study. I am happy to support your research project. I will just need the IRB approval and additional information about the study before I can do so. Just so you know, our list of alumni is a rather generic list of names and email addresses, so I am unable to isolate just those alums who work in outpatient mental health clinics. If it is still helpful for me to send to a more global list, though, I am happy to help. I look forward to hearing from you.

Take care,

Michelle