2019

Relationship Between Socialization Tactics, Military Cultural Competence, and Self-Efficacy of Service Providers Serving Veterans

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This is to certify that the doctoral dissertation by

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The Office of the Provost

Walden University
2019

Abstract

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Proposal Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Military cultural competence has gained attention due to the past 15 years of military conflict and ongoing deployment of troops around the globe. Returning veterans, particularly those who go on to experience homelessness, have reported negative experiences and adverse treatment from programs that were designed to support them. Those experiences have resulted in perceived barriers to access or use of such services. Researchers have established the need for increased levels of military cultural competence to develop rapport with veterans and their families when delivering community-based social and healthcare services. Bandura's self-efficacy theory was the theoretical framework of this study. This study examined the relationship between military cultural competence, socialization tactics, and perceived self-efficacy of service providers employed with Continuum of Care Program member organizations that served veterans experiencing homelessness. Data were collected utilizing a cross-sectional web-based survey. After conducting a bivariate correlation, a statistically significant relationship was found between military cultural competence levels, socialization tactics, and self-efficacy levels. After conducting multiple linear regression, it was found that socialization tactics did not moderate the relationship between military cultural competence levels on self-efficacy levels. Though moderation was not found, leadership of organizations that support veterans may want to consider these factors to inform onboarding and training decisions. Addressing behaviors and attitudes of service providers may support social change by reducing adverse treatment that creates barriers to access and use of programs and services.

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Dedication

I would like first and foremost give honor to my Lord and Savior, whom I look to for all my help. Then to my family, who has been instrumental in my journey; through sacrifices of both time and financial support, as well as being my cheerleaders as I pursued this journey: my husband, Donte Sr., and children David III, Daelyn, Lawren, Larry Jr., Donte Jr., and Candace. I pass the academic baton to each of you to fulfill the plan and purpose for your lives. I would like to especially dedicate this labor of love to two angels who gained their wings during this process, Deonte Sr. and Anastasia. You departed this life at such a young age and were not able to fulfill your dreams but know that you will forever be in our hearts. You both encouraged me during this dissertation journey and your departure has made it more meaningful, so I pursue this degree in your honor.

I can't forget my "ride or die" granddaughter, Tiana Hawkins and sister, Doris Hawkins, who both would wake me up from naps to write or encourage me to reach my targets so that we could watch our favorite episode(s) of whatever was current or partake of our favorite eateries, which kept me balanced and fed. I would also like to thank my military family programs mentor, Lee Ratliff. Your consistent mentorship and encouragement have made this journey worth pursuing. Thanks for believing in me. Lastly, I would be remiss if I didn't include my prayer partner and Sister-In-Christ, Sandra Henry, who has kept me grounded and kept me in prayer.

Acknowledgments

I would like to acknowledge the Walden supervising faculty and academic staff of an awe-inspiring Chair, Dr. Greg Hickman, who kept me humbled, humored, and challenged to be greater, think deeper, and rigorously cite (then cite some more). Without you and the coveted Snoopy Award, I would not have been as motivated to exceed the benchmarks that I had established. Also, Dr. Jennifer Melvin, who served as my first Committee Member and methodologist who always asked the tough but fair questions, while offering positive feedback in the margins. I don't think that you know how inspiring that has been during this journey. Also, I like to acknowledge Dr. Rebecca Stout, who joined "Team Seabrook" late in the journey, as Committee Member, but fell right into lock-step with Dr. Hickman. Your feedback has been very influential in challenging me to look closer at the theoretical foundation. This second look has helped broaden my perspective of how it all ties together. I would like to acknowledge Dr. Sandra Harris, whom I met at my second residency and currently serves as URR. The critical feedback that you have provided emphasized the difference in foundational and doctoral-level writing. You have challenged me to dig deeper to fully realize how social change is operationalized in this study. I would be remiss to not include my initial Chair, Dr. Jim Castleberry, who was my Cohort Advisor at my first residency and stayed in touch through the completion of my coursework. Lastly, I would like to acknowledge Dr. (Major) Eric Meyer, who has not only stayed in touch and expressed an interest in my study but also offering encouragement along the way, even while serving our warfighters on foreign soil.

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Chapter 1: Introduction to the Study

Introduction

Homelessness has been a major crisis in the United States (U.S. Department of Housing and Urban Development [HUD], 2016). The 2015 strategic objective for the federal government to end homelessness identified the need to charge staff of federal, state, local, faith-based, and nonprofit organizations with implementing programs and services to address the phenomenon (HUD, 2016; U.S. Interagency Council on Homelessness [USICH], 2016a). This strategic objective was established after two decades of homelessness was recognized as a grave reality and crisis in the United States (Tsai, Link, Rosenheck, & Pietrzak, 2016). A correlation was found between the expansion of funding and the plethora of homeless programs and services implemented and a 47% reduction in homelessness between 2010 and 2016 (HUD, 2009). Despite these aggressive objectives and recent reduction, the United States is far from ending homelessness (Tsai et al., 2016).

Studies have focused on factors related to homelessness, such as understanding causality (O'Toole, Johnson, Redihan, Borgia, & Rose, 2015; Salem & Ma-Pham, 2015; Toro, 2007), risk factors (Kuehn, 2013; Tsai & Rosenheck, 2015; Washington et al., 2010), and mitigating strategies (Cretzmeyer, Moeckli, & Liu, 2014; Kennedy, Arku, & Cleave, 2017); however, the studies have been limited in addressing the implications of positive and negative effects of service provider interaction and engagement with individuals experiencing homelessness (Jones et al., 2017). Similarly, Woith, Kerber, Astroth, and Jenkins (2016) found that negative past experiences and weak connections

to systems of care were factors and indicators of barriers to access and use programs and services. The results of the study were not clear in identifying whether the negative experiences or weak connections were related to systemic issues or service provider interaction that created the barriers. Negative experiences resulting from adverse treatment may be attributed to several factors including behavior based on stereotypical beliefs (Dickstein, Vogt, Handa, & Litz, 2010; Petrovich & Cronley, 2015), stigma (Cheney et al., 2018), and uncivil behavior of service providers (Woith et al., 2016).

The effects of adverse treatment, such as individualized discrimination and stigma, are similar among veterans and have been reported to have created barriers to access and use programs and services (Cheney et al., 2018). In contrast, Barrett, Clark, Peters, and Caudy (2010) and Weber, Lee, and Martsolf (2017) posited institutions and public systems of care, as well as the behavioral issues of the homeless population, were the barriers to accessing programs and services. Neither researcher examined whether service providers were part of the equation as a possible barrier (Barrett et al., 2010). Along with institutional-based barriers, Weber et al. identified patient-based barriers of veterans to accessing care, such as stigma, without considering the possibility that nurses could also have been a predictor of underuse or unwillingness to return. This gap in the literature helped to shape the need for this study that examined whether the interaction between service providers who serve veterans experiencing homelessness could possibly affect or contribute to the problem of barriers to access and use program and services. There is also a gap in the literature as it relates specifically to reported levels of military

cultural competence, socialization tactics, and levels of perceived self-efficacy of service providers employed with Continuum of Care (CoC) Program member organizations.

This chapter provides a brief background describing the topic of homelessness and the problem of adverse treatment creating barriers to services. I also addressed service provider interaction with individuals experiencing homelessness, specifically veterans, as a part of this study. In this chapter and Chapter 2, I present the theoretical framework of self-efficacy in detail as the foundation for this study. The nature of this study includes the methodology, target population, and relevant definitions of the variables examined in this study. This section is followed by assumptions, the scope and delimitations, limitations, and significance of the study. The chapter closes with a summary to recap the elements.

Background

Service providers who come in contact with veterans need an understanding of military culture, have self-awareness of their own biases, beliefs, and values, and receive appropriate training to serve this population (Bandura, Adams, & Beyer, 1977; Coll, Weiss, & Yarvis, 2011; Kennedy, Jones, & Arita, 2007; Koenig, Maguen, Monroy, Mayott, & Seal, 2014; Matarazzo, Signoracci, Brenner, & Olson-Madden, 2015; Reger, Etherage, Reger, & Gahm, 2008; Ross, Ravindranath, Clay, & Lypson, 2015; Ulberg, Blad, & Newman, 2016)). Without addressing these facets, there is the chance that service provider engagement and interaction may create barriers that deny veterans access to and use of programs and services that were designed to support them (Cheney et al., 2018; Cole, 2014; Convoy & Westphal, 2013; Cretzmeyer et al., 2014; Fox et al.,

2016; Gould et al., 2010). This may be true of service providers delivering programs and services related to the homeless. Service providers who are employees of CoC Program member organizations responded to survey questions in this study to report levels of military cultural competence, socialization tactics used by their organization, and levels of perceived self-efficacy. I examined these responses to test for correlation and statistically significant relationships, as well as to provide evidence of whether socialization tactics moderated the relationship between levels of military cultural competence and levels of perceived self-efficacy.

Levels of military cultural competence have been found to be a factor in relationships between service providers and veterans (Linn, Butler, Bruce, McClain-Meeder, & Meeker, 2015). Meyer, Writer, and Brim (2016 also found that barriers to access and use of services existed at the micro level when medical and mental health staff who were charged with supporting veterans reported a limited understanding of military culture.

Nissen-Lie, Monsen, Ulleberg, and Ronnestad (2013) and Shoji et al. (2016) claimed service provision directly affected outcomes. It is reasonable to apply the same sentiment relating to services provided to veterans experiencing homelessness (Tsai, Mares, & Rosenheck, 2012; Tsai & Rosenheck, 2015). Both Koenig et al. (2014) and Nedegaard and Zwilling (2017) found an understanding of military culture improved outcomes and that if those principles were employed, providers would serve the needs of the veteran population. The researchers supported the belief that higher levels of self-efficacy influences outcomes and can decrease barriers to access and use (Meyer et al.,

2016; Nedegaard & Zwilling, 2017), which formed the basis for this study. The relationship between levels of military cultural competence and whether training increased levels of service provider self-efficacy may shape training strategies (Kennedy et al., 2007; Nedegaard & Zwilling, 2017).

When Cherian and Jacob (2013) conducted a meta-analysis, the researchers found numerous studies focused on training efforts that increased levels of self-efficacy of employees but found a gap in the effect on employee engagement after training and whether employees reported increased levels of self-efficacy. Barden, Sherrell, and Matthews (2017) and Kissil, Davey, and Davey (2015) emphasized the limitations of training as well as employees reporting a lack of knowledge and awareness in serving multicultural populations after training. It would be important to examine multicultural competence and its impact on levels self-efficacy of employees after they have participated in training courses. Equally important is the benefit of examining the effect of socialization tactics when new employees are onboarded to an organization that serves diverse populations, such as veterans.

Problem Statement

There have been numerous strategies developed to specifically address homelessness, such as CoC Programs (HUD, 2016; USICH, 2016b). CoC Programs were organized by HUD to coordinate a range of services needed to support socioeconomically challenged citizens seeking housing solutions (HUD, 2009, 2016; Wong, Park, & Nemon, 2006). CoC Programs are made up of member organizations that employ service providers who serve the homeless population, which includes military veterans

experiencing homelessness or at risk of becoming homeless (HUD, 2009, 2016). A literature review resulted in the discovery that there is a lack of requirement for service providers employed with CoC Program member organizations that serve veterans to understand military culture, the psychological conditions resulting from combat, or how these may affect outcomes for this population (Koenig et al., 2014; Linn et al., 2015; Meyer, Hall-Clark, Hamaoka, & Peterson, 2015). The gap in the literature established a complex paradigm in that higher levels of military cultural competence have been found to improve rapport between service providers and their clients (Koenig et al., 2014), but this has not been mandated as a competence or proficiency for service providers outside of the medical and clinical disciplines (Tanielian et al., 2016; Ulberg et al., 2016). Service providers who can establish rapport and build positive relationships with veterans improve the chances of positive outcomes, such as reducing instances of homelessness (Kuehn, 2013; Montgomery, Byrne, Treglia, & Culhane, 2016; O'Connell, Kasprow, & Rosenheck, 2008; O'Toole et al., 2015; Tsai et al., 2012).

In 2016, efforts to reduce homelessness resulted in a 17% decrease from the year before, but there were still over 39,000 veterans continuing to experience homelessness, with numbers increasing in some geographic areas (HUD, 2016). Actual or perceived barriers have been associated with unwillingness to use services, and these veterans have reported adverse treatment and stereotypical labeling when accessing programs and services (Cheney et al., 2018; Koenig et al., 2014). Similarly, barriers to access, delivery, and use of programs and services were found to be associated with how the homeless perceived they were treated and their inability to relate to service providers (Koenig et al.,

2014; Woith et al., 2016). This behavior consequently led to veterans electing to remain unsheltered (Byrne, Montgomery, & Fargo, 2016; Koenig et al., 2014; Montgomery, Byrne et al., 2016; Nedegaard, 2013). It is not known whether military cultural competence, socialization tactics, or tasks associated with perceived self-efficacy influenced these conditions.

Nedegaard (2013) found military cultural competence to be related to establishing a rapport and overcoming the stigma of help-seeking. To add to that understanding, Nedegaard and Zwilling (2017) examined the relationship between military cultural competence and perceived self-efficacy of civilian providers who served veterans and their families. The researchers found statistically significant relationships of the constructs when surveying mental health, medical, and religious service providers, first responders, and case managers (Nedegaard & Zwilling, 2017). Military cultural competence was positively associated with self-efficacy, though many of the participants had been exposed to military culture or had received some level of related training (Nedegaard & Zwilling, 2017). Training appeared to be one of the influencing factors of self-efficacy levels (Fox et al., 2016), though it is not known whether training alone contributed to the increase or decrease in those levels.

Based on previous studies conducted by Fox et al. (2016), Leppma et al., 2016, Lunenburg (2011), and Linn et al. (2015), I drew the conclusion that leaders of organizations who invest in training to socialize and orient service providers may be attempting to increase competencies and self-efficacy levels of service providers. Jones (1986) found that socialization tactics had a moderating effect on role orientation and

contributed to higher levels of self-efficacy of employees; however, Perrot et al. (2014) found that perceived organizational support was more influential than socialization tactics in supporting newcomer adjustment. Staff employed with organizations that serve veterans may have benefited from leadership supporting the availability of training that focused on military culture to possibly increase levels of self-efficacy (Nedegaard & Zwilling, 2017), whether it was a part of formal or informal socialization. Cretzmeyer et al. (2014) argued training on military culture for service providers who work with veterans and their families might mitigate barriers.

Although the research mentioned above regarding military cultural competence predicting perceived self-efficacy illuminates significant findings with medical students or civilian service providers supporting veterans and their families, I have found no research that has examined the relationship between military cultural competence, socialization tactics, and self-efficacious perceptions of service providers employed with CoC Program member organizations who serve veterans experiencing homelessness. There is also no evidence of examining whether socialization tactics when onboarding these employees to the organization moderated that relationship. Given such, further research is warranted that could examine whether socialization tactics and levels of military cultural competence affects the levels of self-efficacy of nonclinical nonmedical service providers employed with CoC Program member organizations as an effort to address the problem of adverse treatment of veterans experiencing homelessness that causes barriers to access and use of services (Cretzmeyer et al., 2014; Koenig et al., 2014; Woith et al., 2016).

Purpose of the Study

The purpose of this quantitative cross-sectional web-based survey design was to examine whether there is a statistically significant relationship between levels of military cultural competence and levels of perceived self-efficacy of service providers employed with CoC Program member organizations who serve veterans experiencing homelessness. The study also examined whether the relationship between levels of military cultural competence and perceived self-efficacy were moderated by socialization tactics used by member organizations when nonmedical nonclinical service providers were onboarded.

Countless medical and clinical service providers supporting military veterans have reported a limited understanding of military culture, which was considered to have an effect on their ability to establish a rapport with their clients (Coll et al., 2011; Linn et al., 2015; Meyer et al., 2016). Meyer et al. (2015) argued the need for providers to possess military cultural competence to effectively engage with and have the confidence in referring veterans and their families to appropriate resources. The researchers argued military cultural competence may be a predictor of self-efficacy but did not address whether there was a statistically significant relationship when using individualized or institutionalized socialization tactics during onboarding. This study added another dimension to that literature by including data collected from nonmedical, nonclinical service providers employed with CoC Program member organizations.

Research Questions and Hypotheses

RQ1: What is the relationship between levels of military cultural competence and levels of perceived self-efficacy of nonmedical nonclinical service providers

employed with CoC Program member organizations who serve veterans experiencing homelessness?

$H_0$1: There is no statistically significant relationship between levels of military cultural competence and levels of perceived self-efficacy of nonmedical nonclinical service providers employed with CoC Program member organizations who serve veterans experiencing homelessness.

H_a1: There is a statistically significant relationship between levels of military cultural competence and levels of perceived self-efficacy of nonmedical nonclinical service providers employed with CoC program member organizations, who serve veterans experiencing homelessness.

RQ2: What is the relationship between socialization tactics and levels of perceived self-efficacy of nonmedical nonclinical service providers employed with CoC program member organizations who serve veterans experiencing homelessness?

$H_0$2: There is no statistically significant relationship between socialization tactics and levels of perceived self-efficacy of nonmedical nonclinical service providers employed with CoC Program member organizations who serve veterans experiencing homelessness.

H_a2: There is a statistically significant relationship between socialization tactics and levels of perceived self-efficacy of nonmedical nonclinical service providers employed with CoC Program member organizations who serve veterans experiencing homelessness.

RQ3: What is the relationship between levels of military cultural competence and socialization tactics of nonmedical nonclinical service providers employed with CoC Program member organizations who serve veterans experiencing homelessness?

$H_0$3: There is no statistically significant relationship between levels of military cultural competence and individualized versus institutionalized socialization tactics of nonmedical nonclinical service providers employed with CoC Program member organizations who serve veterans experiencing homelessness.

H_a3: There is a statistically significant relationship between levels of military cultural competence and individualized versus institutionalized socialization tactics of nonmedical nonclinical service providers employed with CoC Program member organizations who serve veterans experiencing homelessness.

RQ4: What is the relationship between levels of military cultural competence and levels of perceived self-efficacy when socialization tactics are used by CoC Program member organizations when onboarding nonmedical nonclinical service providers who serve veterans experiencing homelessness?

$H_0$4: There is no statistically significant relationship between levels of military cultural competence and levels of perceived self-efficacy when socialization tactics are used by CoC Program member organizations when onboarding

nonmedical nonclinical service providers who serve veterans experiencing homelessness.

H_a4a: There is a statistically significant relationship between high levels of military cultural competence and high levels of perceived self-efficacy when socialization tactics are used by CoC Program member organizations when onboarding nonmedical nonclinical service providers who serve veterans experiencing homelessness.

H_a4b: There is a statistically significant relationship between high levels of military cultural competence and low levels of perceived self-efficacy when socialization tactics are used by CoC Program member organizations when onboarding nonmedical nonclinical service providers who serve veterans experiencing homelessness.

H_a4c: There is a statistically significant relationship between low levels of military cultural competence and high levels of perceived self-efficacy when CoC Program member organizations use socialization tactics when onboarding nonmedical nonclinical service providers who serve veterans experiencing homelessness.

H_a4d: There is a statistically significant relationship between low levels of military cultural competence and low levels of perceived self-efficacy when CoC Program member organizations use socialization tactics when onboarding nonmedical nonclinical service providers who serve veterans experiencing homelessness.

Theoretical Framework

Self-efficacy theory was the theoretical framework used for this study (Bandura, 1977, 1993). The theory evolved from social cognitive theory and described as the ability to perform more efficiently based on how individuals believe they can satisfy the goal or task (Bandura, 1977, 1986, 1993; Cherian & Jacob, 2013). Self-efficacy is tied to expectations of performance more than expectations of outcomes (Bandura, 1977). Bandura (1993) purported stronger perceptions of higher levels of self-efficacy when completing tasks increased goal-setting levels. Perceived levels of self-efficacy may depend on discipline and the research eludes to the personal mastery of tasks through past experiences and social comparison of self to others better served as the indicator that influenced behavior (Cherian & Jacob, 2013). Cherian and Jacob (2013) found increasing or decreasing self-efficacy levels were positively related to the motivation and performance of employees, complexity of tasks, and the ability to successfully perform the tasks.

According to Bandura (1993), there are four elements that influence self-efficacy: (a) personal mastery of past experiences, (b) effects of social modeling, (c) social persuasion or feedback from others, and (d) physiological arousal that influences behaviors. Rogala et al. (2016) argued exhaustion and disengagement were predictors that affected ability and functioning levels more than past performance and social identity. When Meyer et al. 2015 and Nedegaard and Zwilling (2017) examined the relationship between military cultural competence levels and socialization levels of service providers supporting veterans, the researchers found a statistically significant

relationship, suggesting that higher levels of military cultural competence are predictors of higher levels of self-efficacy. Similarly, Jones (1986) argued a positive relationship exists between using the appropriate socialization tactics for employee orientation and role clarification that affected an employee's performance. For this study, I used self-efficacy theory in the context of service providers' perception of their ability to perform tasks associated with serving veterans experiencing homelessness.

Nature of the Study

The nature of the study was a quantitative cross-sectional web-based survey methodology. Yilmaz (2013) argued that a quantitative approach using a survey or questionnaire offered "comparison and statistical aggregation of data" (p. 313) when testing theories and variables. The convenience sampling strategy (Etikan, Musa, & Alkassim, 2016) employed for this study targeted adult nonmedical, nonclinical service providers employed with CoC Program member organizations in three Southeastern states, Georgia, North Carolina, and South Carolina. Using G*Power 3 (Faul, Erdfelder, Lang, & Buchner, 2007), given the power of .80, the effect size of .15, and alpha of .05 yielded the estimated sample size of 68 using two-tailed, linear multiple regression analysis, with two predictors (Figure 1).

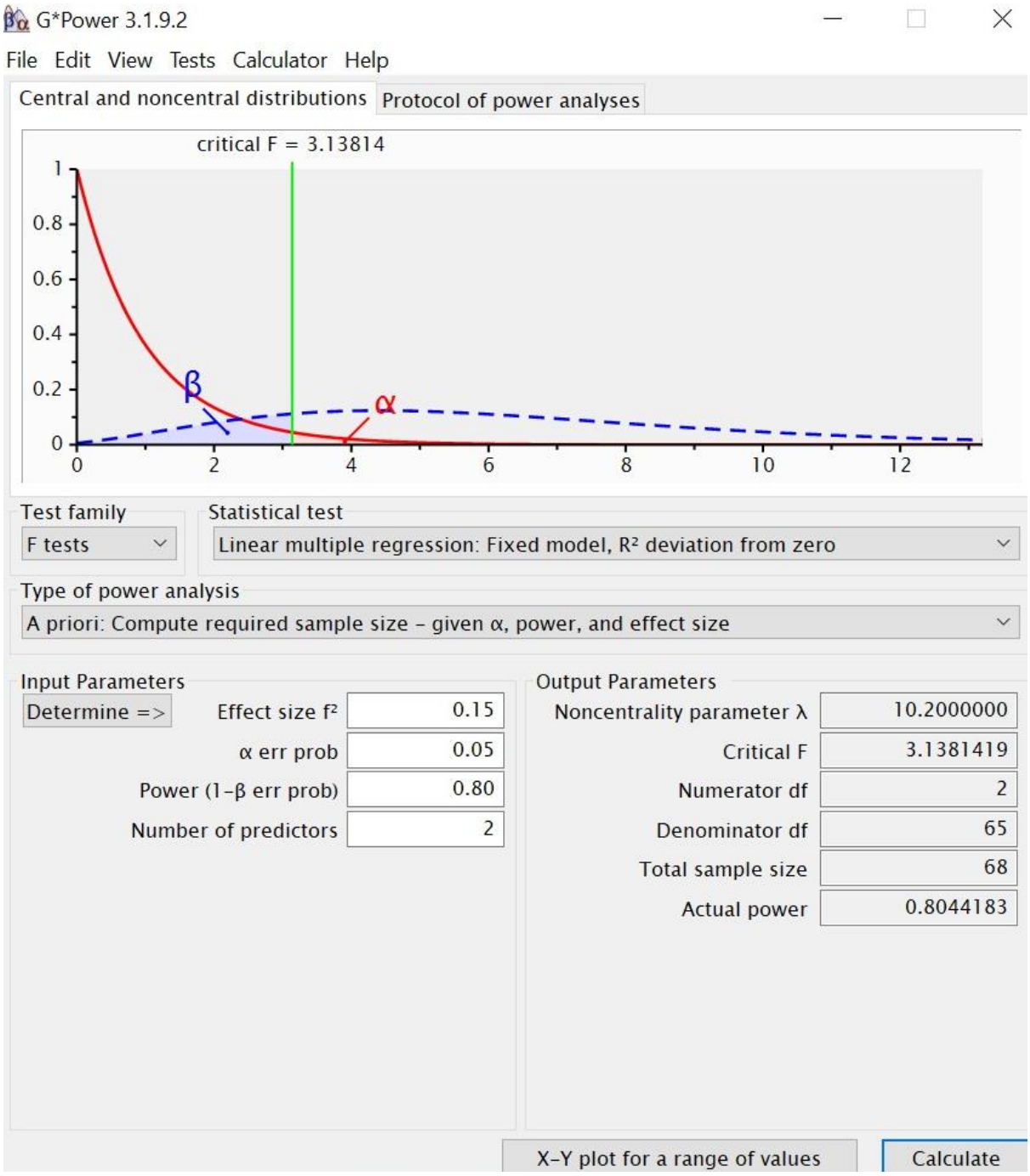

Figure 1. Estimated sample size (G*Power).

Participants were recruited via HUD or nonprofit organization staff responsible for hosting the CoC Program meetings monthly or bimonthly by providing a hardcopy postcard-sized flyer that contained the universal record locator (URL) link to access the web-based survey, furnished by me. I also sent the link to CoC Program organizers via e-mail that notified the potential participants of the study and solicited participation. The web-based survey was available for more than the proposed 3 weeks (a variation described in Chapter 4). The CoC Program organizers sent a follow-up e-mail to the points of contact (POCs) of the member organizations 2 weeks after the initial e-mail as a reminder, but also after I extended the survey period. Participants who responded to the recruitment materials were provided information related to the study and asked to agree to participate through online informed consent.

In the study, I first examined whether there was a statistically significant relationship between military cultural competence, socialization tactics, and perceived self-efficacy of service providers employed with CoC Program member organizations and subsequently whether socialization tactics moderated that relationship. This approach was in alignment with research questions designed to examine the influence and interaction of independent variables and a dependent variable (Yilmaz, 2013).

Variables examined in this study were: (a) military cultural competence (X), independent/predictor variable; (b) socialization (M), independent/moderating variable; and (c) perceived self-efficacy (Y), dependent/outcome variable. Both Meyer et al. (2015) and Nedegaard and Zwilling (2017) found a statistically significant relationship between independent variable military cultural competence and dependent variable,

perceived self-efficacy. Long before Meyer et al.'s and Nedegaard and Zwilling's studies, Jones (1986) had found a statistically significant relationship between socialization tactics and self-efficacy. With the correlational relationship between socialization tactics and self-efficacy found by Jones (1986) and statistically significant relationship found by Nedegaard and Zwilling (2017) between military cultural competence and self-efficacy, I assumed that socialization tactics may moderate that relationship when I examined those variables together in this study. When conducting the literature review, I had not found previous studies that examined socialization tactics as a predictor or moderator of the effect of levels of military cultural competence on levels of perceived self-efficacy.

I collected cross-sectional data via responses to the Military Culture Certificate Program (MCCP) assessment scale (found in Appendix B), which measured responses to statements related to levels of military cultural competence with a 6-point Likert-scale (1 = Strongly disagree to 6 = Strongly agree) and measured responses to statements related to levels of perceived self-efficacy on a continuous scale of 0–100 (see Nedegaard & Zwilling, 2017). Instrument reliability was high with Cronbach's alpha 0.958, for Knowledge and Awareness sections, and 0.943 for Confidences in Abilities section (see Nedegaard & Zwilling, 2017). Socialization tactics were measured using Jones's (1986) six 5-item Socialization Tactics assessment scale (found in Appendix D). The responses to the scale were measured with a 7-point Likert-type scale (1 = Strongly disagree to 7 = strongly agree), and reliability was in the range of 0.68 to .084, though, collapsing the domains into one factor for analysis yielded reliability of alpha 0.84 (see Gruman, Saks,

& Zweig, 2006). Scores of certain responses identified by Jones (1986) were reverse-coded to be directionally appropriate.

Definitions of Terms

Barriers to access and use: Situational or systematic stigmatization and labeling through behaviors or policies that limit access to or use of programs and services (Bonin, Fournier, & Blais, 2007; Vogt, 2011; Zucchero, McDannold, & McInnes, 2016).

CoC Program: The CoC Program consists of a multidisciplinary integrated system of service providers from state, regional, local, religious nonprofit organizations and tribal entities in the United States and the U.S. territories of Puerto Rico, Guam, and the Virgin Islands, which provide support and services designed to end homelessness (HUD, 2016).

Mandated collaboration: Policy that requires the organization to collectively establish comprehensive programming to serve the local needs of citizens to qualify for funding and consideration (Ivery, 2008; Lewis, Boulahanis, & Matheny, 2009).

Military cultural competence: Ability to understand and appreciate the diverse culture of the military, its structure, and specific conditions affecting this population to competently provide services to veterans and their families (Coll et al., 2011; Krueger, 2000; Leppma et al., 2016; Luby, 2012).

Perceived self-efficacy: Individual perception of ability to complete tasks related to their difficulty and prior performance and experiences (Bandura, 1993; Bandura et al., 1977; Cherian & Jacob, 2013).

Socialization tactics: The processes used to acclimate and train employees to understand the organization's mission, their roles and responsibilities, and policies via individualized and institutionalized approaches (Ashforth & Saks, 1996; Perrot et al., 2014; Saks & Ashforth, 1997).

Veterans experiencing homelessness: Individuals separated from the military after serving in the armed services who do not have adequate nighttime accommodations or residence (HUD, 2016).

Web-based surveys: For this study, web-based surveys specifically represented the administering of an online survey through the automated internet program, SurveyMonkey (see Varela et al., 2016; Waclawski, 2012).

Assumptions

Osborne and Waters (2002) and later Ernst and Albers (2017) purported researchers should be cautious when drawing conclusions with multiple regression analysis due to violations of the assumptions of linearity, measurement reliability, homoscedasticity, and normality may increase the risks for Type I and Type II errors. Independence of errors and multicollinearity are also considered assumptions of multiple regression (Ernst & Albers, 2017; Osborne & Waters, 2002). Over and underestimating the effect of relationships between independent and dependent variables, particularly with multiple regression analysis, tend to stretch the boundaries of the detection of errors (Antonakis & Dietz, 2011; Osborne & Waters, 2002). Equally important, MacKinnon (2011) argued the assumptions of moderation analysis might be dependent on the scale,

the detection of the effect may be directly related to the scale, and moderators may increase the chance of a Type I error.

Other assumptions of this study included a sampling strategy conducive to recruiting an adequate number of participants who had an interest in participating through a web-based survey. I also assumed that enough participants would meet the inclusion criteria and voluntarily take part to reach a power analysis of .80. Also, I assumed that individuals who give consent could do so (see Barchard & Williams, 2008). Other assumptions included participants would have access to a computer to participate in a web-based survey and provide honest and timely responses during the identified period of the survey.

Another assumption related to the study was that CoC Program member organizations considered military cultural competence and socialization tactics as important factors in serving veterans experiencing homelessness. With that, I assumed individuals in disciplines, such as doctors, social workers, or therapists, would possess higher levels of self-efficacy based on higher levels of education and training. These professionals who became licensed to deliver respective services may have limited military cultural competence to positively affect the outcomes of veterans (Leppma et al., 2016; Meyer, 2013; Tanielian et al., 2016). It cannot be assumed that by having served in the military there is a connection or camaraderie with patients or clients because the existence of subcultures, program protocols and policies, and unfamiliarity with organizational norms may create an imbalance in efficacy.

Scope and Delimitations

This study was delimited to nonmedical nonclinical service providers employed with CoC Program member organizations, at least 18 years old, employed no less than four months (see Jones, 1986), and preferably less than 18 months (see Cable & Parsons, 2001). Researchers have also identified 12 months as the threshold in other studies (Gruman et al., 2006; Saks & Ashforth, 1997). The preferred time in the position was extended to 18 months to increase the chances to obtain an adequate representative sample size.

Participants were recruited from the southeastern states of Georgia, North Carolina, and South Carolina who were able to give consent in English. Participants did not have to reside in the states identified; they only had to have provided services in an organization with membership in a representative and targeted state CoC Program. Drawing a sample from this 3-state area was a narrow representation of CoC Program member organizations that exist in all 50 states and territories (HUD, 2016). Member organizations may be federal, state, local, religious, or nonprofit (HUD, 2016; Wong et al., 2006). The narrowed location of the geographic region focused in this study limits generalizability beyond this locale and may only be generalized to germane demographics with the same characteristics. Due to the varying nature of CoC Program member organizations, this presented a negative factor for generalizability.

Disciplines and roles of the service providers may include but not limited to administrative, reception, or scheduling staff, nonclinical case managers, volunteer coordinators and volunteers, clergy or religious assistants, human services workers and

interns, lending locker and food bank staff, emergency shelter workers, and teachers/educators. Medical and clinical service providers supporting this population were excluded from this study because they have been extensively represented in a plethora of studies (see Canfield & Weiss, 2015; Cole, 2014; Coll et al., 2011; Elminowski, 2015; Gamache, Rosenheck, & Tessler, 2000; Gould et al., 2010; Hundt et al., 2015; Linn et al., 2015; Meyer et al., 2015; Minick, Kee, Borkat, Cain, & Oparah-Iwobi, 1998; Olenick, Flowers, & Diaz, 2015; O'Toole et al., 2015). Also, this study was not intended to address causation or offer contribution to the empirical evidence that focuses on understanding or providing descriptive statistics of the phenomenon of homelessness among veterans (see Ainslie & Cooper, 2016; Byrne et al., 2016; O'Connell, et al., 2008; Toro, 2007; Tsai et al., 2012; Washington et al., 2010). Instead, the purpose of this study was to examine the relationship between the military cultural competence on the levels of perceived self-efficacy of nonmedical nonclinical service providers who provide care to homeless veterans, as well as whether there was a moderating influence of socializations tactics on that relationship. In light of the scope and delimitations identified, results of this study may have limited generalizability to only populations with similar characteristics of the three southeastern states where data was collected.

Limitations

A convenience sample was employed where participation was voluntary and participants self-selected, which presented a limitation in this study as it could have potentially caused bias when the selection of the sample population was not random (see

Campbell & Stanley, 1963; Etikan et al., 2016; Mackey & Gass, 2005; Onwuegbuzie, 2000; Stanton, 1998). Dörnyei (2007) posited convenience sampling presents a challenge for generalization and may introduce outliers. In addition to bias and unknown influences affecting self-selection, participants indirectly received recruitment materials via e-mail or through sources other than from direct contact with the researcher. Detailed specificity of inclusion criteria was presented as part of the introduction to the study (see Dörnyei, 2007). McKibben and Silvia (2015) cautioned inattentiveness and socially desirable responses might create a limitation in the validity of quantitative survey research, which must be controlled to garner greater accuracy of data. The design of this study supported anonymity, which decreased social desirability and inattentiveness that was addressed by requiring a response to each question before allowing the respondent to advance in the survey (see Wright, 2017)

Findings may not be generalized beyond the small size of the convenience sample of participants of this study (see Campbell & Stanley, 1963), as well as an over representation of participants with military exposure compared to the public (see Nedegaard & Zwilling, 2017) when targeting states with a large military population. Additionally, the purpose, scope, and type of service providers of the CoC member organizations vary by county and state (HUD, 2016); therefore, the data collected may also present limitations for generalization (see Campbell & Stanley, 1963).

Web-based surveys are considered a limitation due to low response rates, unreliability, and social desirability of respondents and inability to clarify questions or intent of researcher (Wright, 2017). Though web-based surveys were found to be as

reliable as telephone or mail survey, motivation and attitudes towards surveys may affect response rate (Andrews, Nonnecke, & Preece, 2003; Fang, Wen, & Prybutok, 2014; Gittleman et al., 2015; Nulty, 2008). Unreliable responses of participants, such as outliers, may need to be discarded, which affects the ability to attain or maintain the required sample size to be deemed reliable (Fang et al., 2014). In spite of the limitations presented in the literature regarding use of surveys, a web-based survey was the most reasonable, timely, and cost-effective means to gather data for this study.

Significance of the Study

The results of this study may inform organizations participating in the CoC Program by providing a different perspective when reviewing policies, procedures, and training portfolios for military cultural sensitivity. Staff of human service organizations, academic programs, organizational leadership, and evaluators of homeless program initiatives may gain an increased understanding of the need for awareness of military cultural competence as it relates to veteran's issues with access and use. This study may assist organizations with establishing strategies for training and onboarding to increase self-efficacy levels in handling situations related to supporting veterans. Stakeholders, such as the service providers, supervisors, organizational leaders, policymakers, and educators may also benefit from these results.

Lastly, results from this study provided awareness and importance of socialization and onboarding practices of employee delivering services to the veteran population and whether military cultural competence increases levels of self-efficacy. Changing the behavior of services providers and opening the aperture of tolerance will

decrease discriminatory and stereotypical reactions and promote the treatment of the less fortunate (regardless of circumstance) with dignity and respect. It is the hope that this study will inform policy and training efforts that address a change in culture in how we treat those who are disenfranchised and marginalized, regardless of our role or interaction

Summary

A lack of awareness of the needs of veterans experiencing homelessness contributes to the systematic failure of service providers to recognize their role in the prevalence and provenance of barriers to access and services to include lack of experience and training to support veterans experiencing homelessness (Applewhite, 1997; Matarazzo et al., 2015; Montgomery, Hill, Kane, & Culhane, 2016; Ross et al., 2015). Gould et al. (2010) posited stigma and barriers are consistent across the armed forces in the United States, as well as in other countries.

Nonmilitary community-based providers have echoed concern with understanding the military culture (Nedegaard & Zwilling, 2017), with fewer than 5% of the United States population having served in the military and the majority of the care received outside of military or Veterans Administration facilities (Meyer et al., 2016). Considering this discovery, lower levels of perceived self-efficacy has the potential to create barriers to services and access for military veterans experiencing homelessness (Donley & Wright, 2012; Gould et al., 2010). Understanding a service provider's perceived self-efficacy informs education and training initiatives for providers and reviews the potential of policies and practices that have a positive impact on the conditions of this population.

I presented the introduction, problem statement, research questions, significance, theoretical framework, as well as terms and limitations related to the study in Chapter 1. Chapter 2 contains the review of relevant and applicable literature and a descriptive summary of studies related to the problem of adverse treatment and barriers to access and use of programs and services for veterans experiencing homelessness. I provided the methodology and design that was used to gather data for the study in Chapter 3.

Chapter 2: Literature Review

Introduction

Adverse treatment of veterans experiencing homelessness has presented a barrier that affected access to care and service use (Biederman, Nichols, & Lindsey, 2013; Bonin et al., 2007; Donley & Wright, 2012; Miller & Keys, 2001). Service providers who support military veterans report that having limited understanding of military culture affects their ability to establish a rapport with veteran clients, which may inadvertently have the same impact on service delivery (Linn et al., 2015). In this study I aimed to provide information about adverse treatment as a barrier for veterans when considering how service providers embrace roles and responsibilities, effectiveness of onboarding and acclimating employees to the workplace (see Ashforth & Saks, 1996), how self-efficacious beliefs are established (see Gruman et al., 2006), and discerning the impact of service providers' attitudes on veterans experiencing homelessness (see Zufferey & Kerr, 2004). Researchers have argued that service providers' cognizance of their relatability to their clients and willingness to advocate for them increases the outcomes for the population and challenges the status quo (Nissen-Lie et al., 2013; Zufferey & Kerr, 2004). Similarly, Brydon-Miller (1997) described consciousness of oppressive actions, policies, and procedures as the process needed for social change. Service providers' relatability and self-efficacious behaviors have established the basis for this study and provide context for the social problem of adverse treatment creating barriers to access and use of programs and services.

In this study, I examined whether levels of military cultural competence predicted levels of perceived self-efficacy among service providers employed with CoC Program member organizations and whether that relationship was moderated by socialization tactics. To establish the basis for this study, I examined the literature to review the historical perspectives and current studies related to military cultural competence, socialization, and factors affecting self-efficacy of service providers. Also, I examined the literature to address the problem of adverse treatment, potential barriers to access and use, onboarding and acclimation, and the relationship between working with veterans experiencing homelessness and perceived self-efficacy of service providers.

The chapter begins with a description of the search strategy used for this literature review. I then present the historical explanation, rationale, and applicability of self-efficacy as the theoretical framework. This section is followed by the representation of the problem of adverse treatment causing barriers that affect access and use of services to confirm the prevalence and prominence of service provider influence. Next, I present the phenomenon of veterans in the United States experiencing homelessness with a comparison to conditions and strategies implemented by U.S. allies, Canada, the United Kingdom, and Australia, to name a few. The section is followed by the categorical themes related to the CoC Program's conception and status. I then introduce the variables: military cultural competence, socialization, and contextual properties of self-efficacy based on relevance to the study. I then offer a review of web-based surveys to explain and support the methodology of this study. This chapter ends with a summary of

the information presented and the relevance and significance of the literature to this study.

Search Strategies

I conducted this literature review to support three major domains, specifically related to the variables of the study, military cultural competence, socialization tactics, and perceived self-efficacy. Additional searches contributed to the problem statement, helped establish the gap, and supported the rationale for the methodology and design. I conducted a key word search by requesting peer-reviewed articles through Academic Search Complete, ProQuest Central, EBSCO, Google Scholar, PSYCHIndex, PsychARTICLES, Mental Measurement Yearbook, Research Gate, SAGE Premier, and Science Direct using the following terms: *perceived self-efficacy, self-efficacy, self-efficacy theory, social cognitive theory, socialization tactics, socialization, military culture, military cultural competence, military cultural competence assessment, cultural competence, barriers to access, barriers to services, barriers to care, use of services, service provider as barrier for homeless veteran, perception of homeless veterans, homeless veterans, homeless veterans in United States, homeless veterans in the United Kingdom, homeless veterans in Canada, homeless veterans in Australia, perception of service providers, HUD continuum of care, housing continuum of care,* and *housing first.* I used Ulrich's Periodical Directory to segregate nonpeer-reviewed journals and conducted a further review to determine the applicability and value of nonpeer-reviewed journals, such as definitions or basis for additional searches.

I sought seminal works prior to 2013 to provide the foundation for the theoretical framework and its application in more recent studies. After retrieving results related to the search terms identified, I conducted additional searches to locate related articles with further narrowing to include results from 2013 or later. I selected other literature for review that contained applicable information such as a working definition, relevant findings, historical and current perspectives on the problem, confirmation of the gap, use and manipulation of variables, and participant population.

In addition to verifying whether studies existed outside of the educational databases, I conducted an online search of the key words identified above in the rare event that peer-reviewed articles and other media were published that could inform the study but were not found in the databases selected. Some of the literature that was relevant to the discipline may have been crouched in public policy or career management but offered value to the study because the moderator variable, socialization, aligns with disciplines outside of the human services but is relevant in this paradigm. I also reviewed research conducted in other countries, such as Australia, United Kingdom, and Canada, for comparison of homelessness, military culture, and whether service providers or mandatory collaboration initiatives were affecting outcomes of the homeless. Given the nature of allied forces supporting the conflicts in the Middle East, I considered it prudent to review the literature of those countries for barriers to service access and efforts to reach individuals experiencing homelessness.

Theoretical Foundation

I chose self-efficacy theory as the foundation of this study, which provided insights into participants' beliefs related to their behavior and personal mastery (see Bandura, 1977, 1993). Bandura's (1977) seminal work has been cited in literature, and the construct of self-efficacy has had an impact on perceptions of ability of professionals performing tasks and functioning in academics, sports, leadership, and providing community services. In this study, I addressed the assumption that a service provider's ability to complete tasks associated with establishing a functional rapport, positive relationship, and ability to relate to veterans experiencing homelessness may increase levels of perceived self-efficacy. Bandura and Adams (1977) argued avoidance of activities when individuals do not believe they can accomplish them, perform effectively, or satisfy a goal or task is associated with their discipline. Service providers supporting veterans experiencing homelessness may avoid individuals experiencing chronic homelessness or give the impression of being less enthusiastic in addressing the veteran's needs.

Service providers who become employees of a CoC member organization will be socialized and acclimated to the organization to understand their roles and responsibilities to assist individuals experiencing homelessness. Bandura and Adams' (1977) argued that individuals would be reluctant to pursue work-related obligations if they believe they lack the skill or training. Service providers who don't believe they possess the knowledge, confidence, or abilities to support veterans may be impacted by a lack of or lower levels of military cultural competence as well as assess to appropriate training. Bandura and

Locke (2003) confirmed support for self-efficacy theory when the researchers argued the difference in the mechanics and human functioning of self-efficacy and goal setting. Self-efficacy was the most appropriate theory to test respondents' reports of their knowledge, confidence, and abilities to perform tasks associated with serving veterans experiencing homelessness.

Literature Review

I presumed from the literature and hypothesized that nonmedical, nonclinical service providers of CoC member organizations who serve military veterans experiencing homelessness, particularly front line workers, will establish a first impression on veterans seeking services, contribute to their experience, and influence their decision to follow through with service delivery. Establishment of first impressions was influential when service providers were responsible for engagement and interaction with clients through interpreting policy related to eligibility, resources, and referrals that affected their working relationships (Cretzmeyer et al., 2014; Kennedy et al., 2017; McMurray-Avila, Gelberg, & Breakey, 1999).

After conducting a search of the literature that addressed issues of veterans experiencing homelessness, military cultural competence, and the effects of self-efficacy, I found a plethora of literature focusing on military cultural competence for medical and mental/behavioral health professionals (see Canfield & Weiss, 2015; Meyer et al., 2015), barriers and stigma to help-seeking behaviors and access to services for medical care (see True, Rigg, & Butler, 2015; Wasserman & Clair, 2013), domestic and international understanding of homelessness (see Ainslie & Cooper, 2016; Toro, 2007), and the

various programs and services developed to respond to the crisis of chronic homelessness (see Montgomery, Hill et al., 2016; Nichols & Doberstein, 2016; O'Campo, Zerger, Gozdzik, Jeyaratnam, & Stergiopoulos, 2015). These studies were limited in examining a nonmedical nonclinical population. The literature review also did not identify research that examined whether there was a statistically significant relationship between military cultural competence and socialization tactics to include whether there was a relationship or influence on perceived self-efficacy. Also, further examination to identify access and use of programs and services by veterans experiencing homelessness was needed to fully understand individual or systemic-level hindrances.

Barriers to Access and Use of Programs and Services

Barriers to access and use of programs and services have been documented, citing reluctance of service providers to treat, particularly when mental health issues are prevalent and there was mistrust of service providers (Bonin et al., 2007; Hoffman & Coffey, 2008; van den Berk-Clark, & McGuire, 2014). The researchers argued experiences with services providers are the greatest indicator of whether individuals will return to treatment. Similarly, Hobbs (2008), Jones et al. (2017), and Cheney et al. (2018) posited that a misunderstanding of the cultural differences in individuals experiencing homelessness had the propensity to contribute to stigmatization and barriers to access and use of programs and services particularly, when serving military veterans. Service providers may be ill equipped or not have the capacity to address the plethora of trauma that predates homelessness for veterans (Perales, Gallaway, Forys-Donahue,

Spiess, & Millikan, 2012; Tsai & Rosenheck, 2013), which incidentally are not always attributed to combat or military service (Lazar, 2014).

Every veteran has not served in combat or diagnosed with mental health illnesses or issues but are subjected to stereotypical attitudes and assumptions about veterans (Dickstein et al., 2010). This is especially true for veterans experiencing homelessness (Donley & Wright, 2012; Knecht & Martinez, 2012). From a historical perspective, Minick et al. (1998) found nurses and nursing student's perceptions of people who were homeless impacted their behaviors and interaction. The researchers found listening, connecting, and increased understanding of the plight of others led to a change in previously held negative beliefs (Minick et al., 1998). Client behaviors may have played a role in the interaction with the nurses and nursing students which shaped the negative feelings (Semeah, Campbell, Cowper, & Peet, 2017; Zrinyi & Balogh, 2004). The assumptions held by the service provider or client in any situation leads to mistrust and reinforces the negative beliefs and stereotypes which creates barriers. (Thompson et al., 2017; Woith et al., 2016).

Those negative reactions of the service provider or veteran could be the result of incongruent expectations and reality of the interaction (Rogers, 2017). The expectations and interactions can be affected by the training received by the nursing staff in how to respond during these engagements. Zrinyi and Balogh (2004), and later, Ulberg et al. (2016) argued training and education and socialization might deconflict personal feelings and beliefs of service providers. A quality training and exposure program that addresses individuals experiencing homelessness may change the perception of services providers

and increase the possibility of clients receiving quality care (Knecht & Martinez, 2009; Leppma et al., 2016). Knowledge transfer attained in an academic setting is not always applied at the work site (Kilpatrick, Best, Smith, Kudler, & Cornelison-Grant, 2011; Leppma et al., 2016).

Knecht and Martinez (2012) found contact with individuals experiencing homelessness to change the attitudes of those exposed. These findings were similar to the researcher's previous study in 2009, except the prior study demonstrated conflict with responses to questions regarding changes in attitudes and subsequent questions that focused on policy and spending. The explanation of the conflict may have stemmed from individual differences in their views about homelessness and the policies that govern support to the population (Knecht & Martinez, 2009). Conflicts and negative perceptions could result in barriers to accessing care and use of services and it would behoove professionals to identify and address those attitudes and beliefs to reduce those barriers (Thompson et al., 2017).

Vogt (2011) argued factors that affected and impacted the use of mental health services for military personnel or veterans was related to public stigma or personal beliefs about mental health. Those factors can be exacerbated by treatment from helping professionals, though Vogt found no association between mental health beliefs and use of programs and services. The researcher purported that limitations existed in the use of undocumented psychometric properties of the instrument, failing to isolate the factors that limit service, and a need to review logistical barriers to care further, and personal accounts of veterans' experiences with stigma and treatment (Vogt, 2011). Veterans have

reported a negative reaction to service providers, which may have increased public- and self-stigma, particularly when provided in civilian health care settings (True et al., 2015; Vogt, 2011).

Stereotypical labeling, stigma, as well as trust plays a critical role in how veterans experience support and willingness to seek treatment (Thompson et al., 2017; True et al., 2015). Though O'Toole et al. (2015) found many veterans did not seek care because they were not sober, not able to keep appointments, or concerned with what might be found, there were several veterans who identified distrust with the VA and self-stigma related to their homelessness. Treatment engagement with the care itself and providers educating patients was seen as motivation and less likely a barrier to veterans seeking health care (Carrola & Corbin-Burdick, 2015; O'Toole et al., 2015). When veterans have a health care need, they have more than one option in seeking care and it would most likely be the facility that offers the requisite services and veterans feel providers can and will meet their needs.

Care at civilian facilities are one of the choices available to veterans even when military-related services offer many benefits, such as access to healthcare resources available at Veterans Affairs (VA) medical centers, if eligible. Hobbs (2008) and Meyer et al. (2015) posited over 30% of veterans are using the Veterans Health Administration, specifically medical centers. A little over 17% are categorized as veterans experiencing homelessness (Tsai et al., 2016) and received care at a VA medical center, which leaves over 80% who received care within their communities by civilian providers. The difference between civilian and military-affiliated medical centers may exist with the

majority of the types of clients served, health conditions presented, as well as cultural differences of ethnicity, race, and gender (Reger et al., 2008; Ross et al., 2015; Tanielian et al., 2016; True et al., 2015). Cultural differences can lead to health inequalities and disparities which require a balancing act between an unresponsive health care system and providers overlooking the cultural diversity of members of the Armed Forces which transcends ethnicity (Olenick et al., 2015; Reger et al., 2008).

Perceived and required cultural competencies of service providers in support of the veteran population were based on what a veteran perceives as significant for their readjustment to civilian life (Ross et al., 2015; Tanielian et al., 2016; Thompson et al., 2017;). Reactions to engagements were found by Koenig et al. (2014) when the researchers conducted a qualitative study and explored the experiences of combat veterans and the ability of providers in healthcare to offer services. Koenig et al. found communications embracing military culture garnered trust and cooperation from the service members and described the promotion of positive and relevant communication as a factor for positive outcomes as service providers were able to establish a rapport and increase trust and buy-in. Patients will provide cues to whether they are receptive to the engagement or interaction with their service provider. It is important to note; combat and noncombat patients may experience their interactions differently dependent on their presenting condition.

Meyer et al. (2016) argued military culture must be tended to in the same fashion as physical and psychological injuries sustained, such as recognizing that it exists and how to navigate cultural expectations during assessment or diagnosis. It was argued

cultural competence must be integrated into training and practice for civilian providers to refer military-affiliated patients to veteran eligible services and other programs, without prejudice (Meyer et al., 2016). Military cultural competence levels of providers translate to the type of behaviors demonstrated by staff, which may be predictor positive or negative outcomes for that experience.

Uncivil behavior of nurses who served the homeless population was identified as stigmatizing behaviors for individuals experiencing homelessness (Woith et al., 2016). Studies that incorporated the perspective of the population served uncovered provider bias and cultural stereotypes, as health care professionals were not immune to disparaging attitudes and behaviors (Woith et al., 2016). The researchers found that negative interactions were not relegated to just racial or ethnic stereotypes, but also identified as biases regarding gender, obesity, mental illness, and substance abuse (Woith et al., 2016). Homelessness in general, may illicit biased attitudes and form stereotypes of service providers which becomes a barrier to individuals accessing or using programs and services.

It has also been argued the adverse treatment experienced by individuals experiencing homelessness stemmed from individual service providers but correlated systemic issues may also exist (Barrett et al., 2010; Kennedy et al., 2017). Kennedy et al. (2017) posited a lack of program funds or availability of housing units was correlated with homelessness, while Barrett et al. (2010) focused on social problems of behavioral health, substance abuse, and criminal justice systems as barriers to access to programs and services. Service providers stressed building positive relationship with individuals

and treating them with respect increased the chance of improving processes and support but participants who lack trust based on past experiences may still have affected outcomes (Kennedy et al., 2017). The expectation of ethical and moral treatment will increase trust and improve help-seeking for individuals experiencing homelessness whether individualized through service providers or systems of care.

Examples of systems of care were found in the literature that addressed strategies and approaches to reduce adverse treatment and barriers to access and use of programs and services. Prior research conducted by Olivet, McGraw, Grandin, and Bassuk (2010) explored and described the experiences of staff of 11 agencies that participated in the Collaborative Initiative to Help End Chronic Homelessness. Olivet et al. presented the Assertive Community Treatment model as a strategy that illuminated staff use of evidence-based practices and approaches to case management. This model allowed time for rapport and relationship building, opportunity to make referrals, follow up with clients to build trust, and provide more comprehensive and deliberate service delivery (Olivet et al., 2010). Zazworsky and Johnson (2014) reported the use of a satisfaction tool for patients to rate care received and service provider to rate their satisfaction with how well they were able to deliver services. However, they did not offer results. In the researcher's examination, partnerships were developed as an innovative collaboration of a mobile model of care that provided health and post-hospital care which decreased the financial impact by reducing hospitalization and emergency room visits for routine care (Zazworsky & Johnson, 2014). In contrast to creating a barrier, the change in service delivery promoted access and use of care (Zazworsky & Johnson, 2014).

Olivet et al. (2010) also found another important discovery during the assessment of the Assertive Community Treatment model, in that nonmedical, nonclinical staff, such as housing coordinators, supportive employment specialists, money managers, and administrative assistants, worked closely with the team but were not identified as part of the team). This distinction could prove troublesome to a team which encompasses multiple agencies, policies, and services, such as CoC Programs that serve individuals experiencing homelessness (Wong et al., 2006), who may be the most susceptible to adverse treatment. Based on the review of the literature, I concluded that inexperienced staff may not have the professional acumen or experience to overcome the demands of providing services to the chronically homeless population. Development of evidence-based practices (Olivet et al., 2010) and innovative tools to access service delivery (Zazworsky & Johnson, 2014) to serve a unique population, like veterans experiencing homelessness, may improve outcomes and reduce barriers.

Veterans Experiencing Homelessness

Veterans experiencing homelessness is a subset of the veteran population served by civilian service providers (Montgomery, Byrne et al., 2016; Segaert & Bauer, 2015; Tsai et al., 2012; Tsai et al., 2016; Washington et al., 2010). Higher levels of military cultural competence through exposure or prior military service did not explicitly guarantee higher levels of perceived self-efficacy (Nedegaard & Zwilling, 2017). Self-efficacy is related to an individual's belief that he/she possesses the knowledge, confidence, and abilities to accomplish tasks or goals (Bandura, 1993).

According to the 2016 U.S. Census population estimates, of the 429,109 individuals experiencing homelessness, more than 39,000 are veterans, representing 9.2% of the population (HUD, 2016). Previously Dail (2000) reported more than 40% of the U. S. homeless population were veterans. According to 38 U.S. Code 101, veterans are considered persons who have served in the active military, to include naval or air service, and were discharged or released from duty under honorable conditions (Legal Information Institute, 2017). Homelessness was defined as not having habitable accommodations or nighttime dwelling (HUD, 2016), though the consensus of definition contributes to the inconsistency in the reporting of statistics. Together, these definitions provide the basis for the subject population who come in contact with the nonclinical, nonmedical service providers targeted in this study.

In the 3-state region of this study, veterans experiencing homeless are estimated as 1,055 in Georgia, 888 in North Carolina, and 738 in South Carolina (HUD, 2016). The largest demographic was representative of white males (90.7%) compared to women (8.6 %) and transgender (.7%) (HUD, 2016). African Americans are the next largest population for an estimated 12,987 (23.9%), with all other races reported as 3,519 (15.9%) (HUD, 2016). Dail (2000) argued African Americans are disproportionately represented in the homeless statistics, similar to poverty statistics, though in the demographics for the 3-state area of interest for the study, African Americans are not the majority. Similarly, Kuehn (2013) presented Metraux's argument regarding the risk factors and causes of homelessness of veterans utilizing the 2005-2006 VA data, which

debunked some of the research findings of male veterans disproportionately exceeding women for risk factors (Kuehn, 2013).

Homelessness was a worldwide phenomenon that extends beyond the borders of the U.S. to other developed countries such as Australia, United Kingdom, Canada, and Japan (Bonin et al., 2007; Kennedy et al., 2017; Toro, 2007). Military veterans participating in conflicts alongside U.S. forces, experience similar predicaments after transition to the civilian sector, such as economic instability, physical and psychological trauma, substance dependence; which have been directly linked to experiences of homelessness (Toro, 2007). Lazier, Gawne, and Williamson (2016) supported this discovery when the researchers presented evidence to support service members who lose the stability of a regular and predictable income stream caused financial instability led to homelessness in the United States, as well as countries of allied armed forces. The state of veteran conditions was previously disputed by Creamer, Morris, Biddle, and Elliott (1999), stating veterans from Australia, an ally of the United States, experienced better treatment outcomes related to posttraumatic stress disorder of Australian veterans and argued veterans experiencing homelessness as nonexistent with lower levels of comorbidity. Cobb-Clark, Herault, Scutella, and Tseng (2016) also confirmed the nonissue of veterans experiencing homelessness in Australia. It was not understood whether the definition of veterans or willingness of individuals identifying themselves as veterans affected the reporting of accurate statistics.

Canada, Australia, United Kingdom, and the United States have not been as fortunate in comorbidity levels or number of individuals experiencing homelessness

(Creamer et al., 1999; Montgomery, Byrne et al., 2016; Parsell, Jones, & Head, 2013;). On the contrary, Parsell et al. (2013) identified policies to reduce homelessness in Australia but failed to identify a numerical value or percentage or even if veterans were included; however, the researchers eluded to an emergency response to homelessness as early as the mid-1980s. The definition of homelessness was considered sleeping rough in the streets in London and Australia, compared to the definition used by the U.S. relating to a habitable residence (Parsell et al., 2013). Policy and program implementation increased beginning in Australia in 2000 and as late as 2007 (Parsell et al., 2013) Australia modeled the systems of both United Kingdom and the United States but was more closely aligned with the United Kingdom because they both considered homelessness a social problem (Parsell et al., 2013). An international approach to homelessness allowed greater examples of successful evidenced-based programs and policies.

In 2007, Toro examined homelessness across developed nations and established the framework for the need to address the phenomenon holistically; as the isolated approach was more troubling than having no approach at all. The United States trailed other countries in the welfare of its homeless, particularly related to single adults, which was represented in each country; however, in the United States the individuals are depicted as plagued with trauma; creating a people-centered causation versus a social-cultural or policy-induced effect, like in Europe (Toro, 2007). The researchers found the need for a cross-cultural understanding of homelessness, but the literature failed to include the military as a culture. This oversight may be due to the length of the conflict,

having only reached six years at the time of the publishing of the article and too little was known at that time about the effects of war as a risk factor for physical and mental health issues that increased risk factors for homelessness.

Homelessness, in general, has certain risks factors that complicate housing stability, with most caused by a change in circumstances. For veterans, transition from active duty or being released from active duty can be complicated when other changes occur (e.g., divorce, loss of job, physical or mental health issues, etc.) (Ahern et al., 2015). These changes can increase risk factors for homelessness but do not necessarily negate protective factors possessed by individuals (Ahern et al., 2015). When individuals encounter such changes, it was just one factor that contributes to homelessness; in many cases the causes are multiplicative.

In Arizona, the chronic homeless was estimated at 17.6%, majority male and older than 45 years old (Zazworsky & Johnson, 2014). Zazworsky and Johnson (2014) posited the community-based approach includes partnerships between health and social systems to create a continuum of care that involved clinical outcomes. The concept of village and continuum of care in health care collaboration was presented with social science patterns to deliver holistically and wrap-around services to the homeless utilizing a van to render mobile services (Zazworsky & Johnson, 2014). The review of wraparound services which included case managers was presented but no other information was offered to address orientation and training program for the staff to fully assess the impact of partnerships and relationships (Zazworsky & Johnson, 2014).

Tsai et al. (2016) examined the prevalence of homelessness from a nationally representative sample, usage rates of Veterans Affairs (VA) homeless and social services, and sociodemographic and clinical characteristics. Data was collected during Wave 3 of the National Health and Research in Veterans Study, assessing homelessness among 1,533 U.S. veterans between July and August 2015 of the 2011-2015 range (Tsai et al., 2016). It was concluded one of every six veterans used VA homeless and social services while homeless, though veterans may have known the program or service by name (Tsai et al., 2016). There was a gap between the estimated need and actual service delivery, particularly for veterans residing in rural areas (Tsai et al., 2016), as well when comparing veterans to nonveterans (Tsai et al., 2012). The researchers did not indicate whether barriers to use of VA homeless or social services programs existed or whether statistical representation of the veteran population failed to include risk factors associated with misconduct related or dishonorably discharges (Tsai et al., 2016).

Similar to the United States, in Canada veterans are defined as individuals who formerly served in the Canadian Armed Forces, went through training, and then released (Veteran Affairs Canada, 2015). Statisticians estimated 697,400 veterans in Canada but lacked the ability to consistently provided estimates of those veterans experiencing homelessness, 7% were reported in metro Vancouver, as well as Toronto, 5% in the Waterloo region, and 6% in Alberta's region (Segaert & Bauer, 2015). The demographic characteristics of veterans experiencing homelessness in Canada are much like in the United States, with the majority male and average of 52.8 years of age; though veterans using shelters were on an average of 41.6 years of age (Segaert & Bauer, 2015).

Segaert and Bauer (2015) found the top ten reasons for service at shelters was consistent for veterans and nonveterans in Canada: lack of housing, family/relationship breakdown, transient lifestyle, financial crisis, eviction by landlord, discharge from correction/jail, new arrival to area, stranded in area, eviction by other than landlord, and unsafe housing. The inability to offer valid and consistent estimates for veterans experiencing homelessness are based on the findings that several individuals choosing to remain unsheltered, which was considered sleeping rough; however, there was no explanation provided in the report to support the reason for 11% of veterans experiencing homelessness sleeping rough compared to the 7% using shelter resources (Segaert & Bauer, 2015). These conditions identified as reasons for homelessness are very similar to the United States in approach.

Snow, Baker, and Lazier et al. (2016) reiterated the 1956 commitment of General Omar Bradley to reduce homelessness among veterans through the compensation of veteran's pensions. Some 60 years later, there continues to be a disconnect between community reintegration and positive outcomes for veterans. Veterans experiencing or at risk of becoming homeless are reportable as a category on the HUD (2016) annual statistics and the primary charge of federal organizations, such as USICH (2016a) and National Coalition of Homeless Veterans (NCHV) (2015), as well as state, local, and nonprofit organizations that participate in CoC Programs, as described in further detail in the following section.

CoC Programs

Dail (2000), as well as Wong et al. (2006), offered Stewart B. McKinney Homeless Assistance Act of 1987 (later named the McKinney-Vento Homeless Assistance Act), Presidential Executive Order 12848 of 1993, and Barnard-Columbia Center for Urban Policy of 1996 as the historical responses to homelessness through law and policy development. The CoC model was borne out of the McKinney-Vento Homeless Assistance Act to establish multi-tier systematic and collaborative support for the homeless population (HUD, 2009; Wong et al., 2006). Services were previously delivered haphazardly, with no accountability or responsibility for the outcomes of persons served (Hambrick & Rog, 2000) or consensus on coordination, though mandated (Dail, 2000). The Robert Wood Johnson Foundation's evaluation of programs for the homeless predates the CoC program development, which found the need for a comprehensive and collaborative service delivery option to improve outcomes (Hambrick & Rog, 2000).

Lead agencies were tasked by HUD but varied by location, though the representatives of those agencies had the same responsibility to improve housing practices and performance of CoC programs (National Alliance to End Homelessness (NAEH), 2017). Not exclusively or by design, many of CoC programs are near military installations, bases, or posts (NAEH, 2017; NCHV, 2015) and those areas tend to have a higher military veteran population. The COC Program is comprised of several federal, state, local, religious, and other nonprofit organizations (HUD, 2016), whose member organizations employ service providers from varying disciplines.

The CoC Program model was designed to establish a model on the local level to better equip individuals experiencing homelessness to become self-sufficient and increase chances of achieving permanent housing (Wong et al., 2006). The four parts of the continuum include: 1) outreach, intake, and assessment, 2) emergency shelter, 3) transitional housing, and 4) permanent and permanent supportive housing (NAEH, 2010). Emergency shelter placements were designed to offer short term solutions, six months or less, and transitional housing serves as the bridging strategy between emergency housing and permanent supportive housing (Wong et al., 2006). Wong et al. (2006) conducted a study that focused on operational characteristics, management practices, and service provision by program managers and staff of CoC member organizations that identified touch points for client interaction. Employees tended to pay more attention to clients who were better functioning and have a greater chance of becoming self-sufficient and denied services to clients considered unstable and with functional disabilities (Wong et al., 2006). The mandated collaboration and coordination of efforts of the member organizations delivering CoC programs and services also require consensus and standardization of rules and processes (Ivery, 2008; Wong et al., 2006). A lack of conformity and standardization support confounding issues that increase barriers to access and service use but also limits staff in understanding the organization's mission and their roles regardless of program type or functioning level of clients (Wong et al., 2006).

A similar collaborative model in England where homelessness services were incorporated into what Moseley and James (2008) referred to as meta-governance.

Compliance with local collaboration policies and processes offered reductions in redundancies and filled service gaps through opportunities for funding of local programs and services (Moseley & James, 2008). In the United Kingdom, there was no single governance, so a collaborative approach offered the ability to govern while allowing organizations to individually offer support according to organization's independent mission while reaching a common goal (Moseley & James, 2008). The informal and formal networks both detected and effected authority-, information-, and incentive-based strategies that supported mandated collaboration (Moseley & James, 2008and offered long term benefits for organizations supporting individuals experiencing homelessness, much like the CoC Programs in the United States (Ivery, 2008); however, both have implications that have abandoned or modified organizational processes.

Collaboration requires professional relationships among the stakeholders to achieve a common goal (Lewis et al., 2009). Southeastern Louisiana mandated collaborative model is one such representation that has banded together to receive government funds to address chronic homelessness within their catchment area (Lewis et al., 2009). Similar to the Joined-Up Governance of the United Kingdom and the National Homeless Initiative in Canada, the CoC program in the United States were more reactive to the plight of homelessness, than reactive (Lewis et al., 2009). Collaborative models show promise; however, each model notes a concern for front line workers whose needs are difference than that of the organization represented in the collaboration, which entails funds and training to meet the demands to interface with the homeless population (Lewis et al., 2009). To that point, there has been a consistent need for additional research to

fully understand the perspectives and needs of front line workers of these mandated collaborative efforts, such as the collaboration of CoC Program member organizations.

The perspectives of front line workers, such as service providers supporting the chronic homeless population, were the focus of the qualitative case study that identified the complexity of the plight of the homeless in Canada (Kennedy et al., 2017). Realizing the need for multi-agency approach, the Region of Waterloo, coordinated a strategy that addressed barriers to housing stability at the individual and systemic levels that included supportive housing and intensive wrap-around services (Kennedy et al., 2017). The ten agencies at 18 sites are a part of STEP Home, which is similar to CoC Programs, and are responsible for coordinating strategy to address barriers to housing stability at the individual and system levels through supportive housing and intensive wrap-around services (Kennedy et al., 2017).

Research Variables

Research variables examined in this study were military cultural competence, an independent variable, considered the predictor variable; socialization, another independent variable, potential moderating variable; and perceived self-efficacy, the dependent variable/outcome variable. Previous studies and meta-analysis have established relationships between military cultural competence and self-efficacy Meyer et al., 2016; Nedegaard & Zwilling, 2017), as well as socialization and self-efficacy (Jones, 1986; Saks & Ashforth, 1997). However, there were no studies found that examined whether socialization tactics moderated the relationship between levels of military

cultural competence on levels of perceived self-efficacy. This study examined those relationships to include moderating effects of socialization tactics.

Military Cultural Competence

Military service shapes identity, practices, and risks of veterans, while veteran health outcomes are predicated on a service provider's levels of military cultural competence (Tanielian et al., 2016; Ulberg et al., 2016). Service providers who serve veterans require specific knowledge to reduce exacerbating one condition that may go untreated when following status quo treatment protocols (Hobbs, 2008). Race and ethnicity have been the most studied cultural phenomenon but did not fully encompass cultural diversity (Kumas-Tan, Beagan, Loppie, MacLeod, & Frank, 2007; Meyer, 2013). Kumas-Tan et al. (2007) argued culture transcended ethnicity after measuring and analyzing cultural competence over 20 years. Prominent instruments that measured cultural competence that offered the most discriminating evidence of six assumptions identified implications for practice: culture as synonymous with ethnicity and race, a lack exposure and familiarity signified the other race as the problem, practitioners are White and Western, biases, prejudices, and discriminating behavior towards others, and practitioners are considered competent if they have confidence in working with others (Kumas-Tan et al., 2007). The review of the cultural differences addressed general analysis (Kumas-Tan et al., 2007); however, the culture and subcultures of military experience or lifestyle to include combat veterans were not included (Meyer, 2013). Failure to examine this phenomenon prevents service providers from recognizing the effect culture may have on civilian service providers serving veterans.

Military cultural competence started gaining traction after the realization that the war in Iraq and Afghanistan was not going to end as quickly as Desert Storm/Desert Shield (Lazier et al., 2016; Matarazzo et al., 2015). Because the conflict did not dissipate quickly, the return of service members and their transition to civilian providers quickly became problematic (Danish & Antonides, 2013; Pease, Billera, & Gerard, 2016; Tanielian et al., 2016). The transition to the civilian communities was not as smooth or seamless as the transition programs advertised and military cultural competence in the civilian community became a necessity (Cole, 2014; Danish & Antonides, 2013).

For the most part, the focus on military cultural competence has been concentrated in training and education programs for medical and clinical service providers, such as doctors on residence, nurses, social workers, counselors, and therapists expected to provide treatment to this returning military population (Tanielian et al., 2016). There has been no emphasis on nonmedical nonclinical staff who are charged with entry-level, front line roles and have immediate interaction with veterans seeking services. Help-seeking behaviors demonstrated was the first step for many service members to process their feels about war, their transition, or their need for additional services and first impressions can have a profound effect on how some veteran views the entire organization (Koenig et al., 2014).

A provider's view of their cultural competence levels will shape perceptions of their response to others (Kissil et al., 2015). Nissen-Lie et al. (2013) purported self-perceptions of therapists were not always congruent with the patients' impression. Therapists who are hostile or lack professional decorum have a negative effect on

treatment outcomes (Nissen-Lie et al., 2013). The researchers hypothesized a predictive relationship between professional self-doubt, negative personal reaction, and advanced relational style with the possible nondirectional mediation of warm interpersonal style (Nissen-Lie et al., 2013). It can be inferred that exposure to the military population will most likely increase understanding of military culture (Meyer, 2013; Nedegaard & Zwilling, 2017) which may also be said about exposure to individuals experiencing homelessness to offer insight into the associated cultural aspects (Knecht & Martinez, 2009, 2012).

Cultural competence has been measured in a variety of ways, starting with Mason's (1995) assessment scale, which asked questions related to the practitioner's work with people of color. The verbiage associated with this assessment scale would not meet the current ethical and political environment. Multicultural competence was of interest to Holcomb-McCoy and Myers (1999) when the researchers studied competencies of professional counselors and found a 5-factor model of knowledge, awareness, definitions, racial identity development, and skills (Barden et al., 2017). There has been a shift since Holcomb-McCoy and Myers (1999) had this discovery, when Barden et al. (2017) replicated the study utilizing the Multicultural Counseling Competence and Training Survey and found only knowledge and awareness as statistically significant. The researchers also found a statistically significant relationship between race and education level, with nonCaucasian/White participants reporting higher levels of perceived knowledge and awareness of multicultural issues (Barden et al., 2017). Unlike current research and evidence, the researchers did not find a statistically

significance between those who received multicultural competence training and those who didn't (Barden et al., 2017). Barden et al. reported limitations of a low response rate, self-report of competence level, and predominantly Caucasian participants in the study. Also, this study informed perceptions of knowledge and awareness relating to cultural competence but did not consider the diversity of individuals who have served in the military and the instrument did not address related factors (Barden et al., 2017).

To date, several assessment tools have addressed diversity and cultural differences between employees and customers (Babin & Boles, 1996) and practitioners and clients (Ross et al., 2015). It was not until Meyer et al. (2015), then subsequently Nedegaard and Zwilling (2017), was there a substantive instrument designed to measure cultural competence as it relates to military members and their families. Tanielian et al. (2016) argued military cultural competence as a significant indicator of positive outcomes in clinical care of service members returning from combat with physical and psychological wounds of war. This is particularly true for military providers who support other service members (Ross et al., 2015). Researchers found that recently presented scales that focused on physical, mental, and behavioral health were limited in providing a full comparison of effectiveness and proposed outcomes for active duty service members, veterans, and their families when seeking services in the civilian community when supported by nonmedical, nonclinical providers (Tanielian et al., 2016).

Luby (2012) argued increasing community capacity to support the veteran population also required an increase in knowledge and understanding of military cultural competence for civilian service providers. Matarazzo et al. (2015) considered this a

problem for many counselors, particularly in rural areas, who had not been able to justify resources to get appropriate military cultural competence training to serve veterans. Service provider's socialization and onboarding efforts and tactics were hypothesized in this study, in that it may have affected the role of supporting veterans experiencing homelessness influenced by the understanding of organizational mission and attitude toward veterans.

Danish and Antonides (2013) argued the needed to differentiate between service members returning from Iraq and Afghanistan with reintegration and health issues resulting from combat-related stressors or with a transition to civilian life. The ability to understand changes in interpersonal, personal, emotional and cognitive, physical, and spirituality all play a vital role in understanding the shifts service members go through to reintegrate after combat (Danish & Antonides, 2013). A life skills approach to reintegration through the Life Development Intervention framework as proposed by the researchers was identified as focusing on teaching the necessary goal-setting skills for transitioning from one environment to another (Danish & Antonides, 2013). Training of psychologists, counselors, and social workers have focused mainly on cognitive and behavioral goals (Canfield & Weiss, 2015), yet this new approach that offers training directly to the veteran and their families was a shift from the traditional training or resources available to support this population (Danish & Antonides, 2013). This shift offered a resource of a life skills intervention model to increase help-seeking behaviors and minimizing the stigma associated with receiving help (Danish & Antonides, 2013), even when providers are not aware of the veteran status.

Veteran status was not intuitive when individuals presented to organizations to request assistance or support (Kilpatrick et al., 2011). Scenarios that involved service providers who asked about military service at first contact better established the premise of productive conversations (Convoy & Westphal, 2013; Kilpatrick et al., 2011; Ulberg et al., 2016). It was argued the insights of military culture informed care and response to veterans directly affected outcomes (Convoy & Westphal, 2013). Collaboration of civilian facilities and the Veterans Administration provide the best condition for current or former military service members to provide a comprehensive triage that may unmask underlying symptoms related to cultural factors not first discovered by traditional triage (Convoy & Westphal, 2013; Cretzmeyer et al., 2014). A connection must exist between education and practical application in addition to relevant curriculum content and useful internships to have an effect or increase outcomes of students and future clients (Barden et al., 2017; Elminowski, 2015).

Elminowski's (2015) mixed-methods study examined Leininger's (2008) cultural care, diversity, and universality theory to determine whether in the differences and similarities for nurses after a 3-hour workshop on cultural awareness pertaining to the culture of others, which found that after applying knowledge, there was an increase in competence. The nurse practitioners' pretest and posttest scores, as well as a reported decrease in emergency room visits and hospitalizations of their patients was evidence of having a positive effect on the experience of their patients (Elminowski, 2015). Reduction in taking an egalitarianism posture and actively seeking to understand others and also respecting the culture of others provided a more conducive environment for

quality in care and reducing barriers to use (Ahern et al., 2015; Cheney et al., 2018; Cretzmeyer et al., 2014).

The qualitative study conducted by Linn et al. (2015) explored how to better prepare social workers and nursing students to serve veterans and their families. Semi-structured interviews in focus groups were conducted to understand the student's experience of working with veterans, their view of their training experience shaping perceived self-efficacy, and future need for curriculum content development. In other health care settings, Fox et al. (2016) posited obstacles to cultural competence training when providers believe they are already culturally competent. When providing gender sensitivity training to veterans' affairs' employees to better prepare them to serve women veterans, strengths were found in evidence-based quality implementation (EBQI) training over the standard web-based implementation (Fox et al., 2016). Strength was found in the EBQI group training format with leadership and relevant stakeholder support; however, available resources may present logistical challenges to deliver the training (Fox et al., 2016). Local context aligned with evidence-based strategies, along with assessing gender sensitivity and knowledge, has improved ability to serve women veterans through the Caring for Women Veterans initiative, mainly because cultural competence training had previously focused on race and ethnicity (Fox et al., 2016).

In another health care setting, Leppma et al. (2016) examined the requisite of professional competencies of psychologists and counselors in working with military veterans and their families. Competency domains are identified as psychological, emotional, physical, issues related to reintegration, military culture, military training, and

research on evidence-based practices (Leppma et al., 2016). Of the 23 competencies, the participants who have a history of working directly with veterans, reached a consensus of awareness of own values and beliefs, awareness of client's worldview, and culturally appropriate intervention strategies as the three domains (Leppma et al., 2016). Multicultural differences of service branches, era of service, job, and individual experiences in military each pose the question of differences in competencies, values, and beliefs to support for each of the differences. Leppma et al. reported limitations in a lack of standardized approach to training graduates to work with the veteran population, possible issues with clarity of instructions to complete the survey, items of the survey, and relevance of terms, that may affect findings in study.

Shoji et al. (2016) conducted a meta-analysis of literature, 57 studies which consisted of over 22,000 participants, to review association of self-efficacy and job burnout with consideration to factors of self-regulation. The researchers utilized the self-efficacy theory of Bandura (1986) in relation to social cognition and found different associations of self-efficacy (Shoji et al., 2016). These associations were considered protective factors in relation to different components of job burnout (Shoji et al., 2016). Shoji et al. also postulated self-efficacy in the context of a self-regulated behavior in relation to burnout and perceived self-efficacy as a protective factor against job stress. Findings in this meta-analysis argued Bandura's (1993) social cognitive theory as a reciprocating factor in comparative methodology of self-efficacy and burnout (Shoji et al., 2016).

Reger et al.(2008) argued the role of civilian psychologists in an Army environment have an obligation to understand the Army's culture to facilitate ethical treatment of service members, even when the providers come from the civilian sector. The language of service members to include acronyms, an understanding of rank structure, and belief systems present a unique challenge for service providers completing an ethical assessment and qualified treatment of this population (Reger et al., 2008). Service members who serve as psychologists attend military training unlike their civilian counterparts, though they both have the responsibility of providing competent services to the military and veterans; though they may work in a military hospital, they will only be exposed to the military-medical culture; not the full spectrum of military service exposure (Reger et al., 2008). Reger et al. also argued the need for training on regulations and documents, as well as training through direct observation; stressing the need for formalized training.

Pease et al. (2016) amplified the need for military cultural competence of service providers to fully understand or be aware of veterans' feelings of brokenness or burdensome instilled through military inculcation, even if unintentionally. Canfield and Weiss (2015), Carrola and Corbin-Burdick (2015), and Thompson et al. (2017) argued the need to integrate military and veteran culture in social work and counselor education and practice. The Council on Social Work Education tracks the specialized training and skills necessary to perform military social work or address veteran's issues upon graduation (Canfield & Weiss, 2015). Canfield and Weiss also argued limited educational training on military culture did not fully equip social workers to serve this

population without first addressing their behavior, values, and biases about the military or any thoughts that may influence their perceptions and attitudes.

Veteran-centered curriculum suggestions of noted importance and relevance to this study included Veterans Health Administration use, military cultural competence/consciousness, and empathic communication (Ross et al., 2015). The latter was a skill already associated with health care principles but when it was compounded with the need of culture, the attention given to the provider's own beliefs, assumptions, and barriers to access and service use (Ross et al., 2015). Ross et al. (2015) study focused on the training outcomes of 31% of the 100 medical schools and health systems, to include three international schools, to improve health care outcomes, yet would need to take one step further in identifying the implications of training outcomes to employee socialization of employing organizations and impact on outcomes of veterans served (Ross et al., 2015). Seventy-one percent of respondents reported confidence working with veterans, though there was conflicting evidence of their knowledge of veteran health-related conditions (Ross et al., 2015).

Socialization Tactics

Socialization tactics are the process of acclimating and training employees to understand the organization's processes to include mission, roles and responsibilities, and policies via individualized and institutionalized approaches (Ashforth & Saks, 1996; Jones, 1986). Jones (1986) expounded on Van Maanen and Schein's (1979) theoretical position related to socialization and developed the socialization tactics scale to measure processes for newcomers to socialize to organizations and influence personal outcomes,

role orientation, and the response of the employees (Jones, 1986). Jones (1986) found significant relationships between investiture and serial processes and moderating the effects of institutionalized tactics; which was contrary to the resultant suggestions of high self-efficacy determining how they establish their roles or progress in the organization. The researcher measured the socialization tactics at Time 1 to assess the newcomer's socialization experiences, with outcomes were measured at Time 2 (Jones, 1986). Jones (1986) found that higher levels of self-efficacy of employees have a moderating effect on role orientation and socialization tactics. Self-efficacy was measured based on an individual's perception of whether they can complete tasks assigned and may influence an employee's adjustment to an organization, along with the tactics used by the organization.

Subsequently, Allen and Meyer (1990) attempted to replicate Jones's (1986) findings and longitudinally examine the relationship between socialization tactics and outcomes by measuring tactics, role orientation, and organizational commitment. The study participants included two classes of undergraduate and graduate business students at six and 12 months after graduation (Allen & Meyer, 1990). Again, socialization tactics were measured at the 6-month mark with the Jones's six 5-item scales and role orientation modified measure at both the 6-month and 12-month marks, along with an Affective Commitment Scale and Organizational Commitment Questionnaire (Allen & Meyer, 1990). The researchers found the tactics used at six months are not what holds at 12 months and organizations should consider tailoring their tactics to increase commitment role orientation (Allen & Meyer, 1990). Employees who work with

incumbent employees may limit innovation by maintaining the status quo and should be given the opportunity to develop their own strategies to develop their own identity (Allen & Meyer, 1990). Most of the studies identified thus far had included participants graduating from business school to address individualized and institutionalized experiences (Jones, 1986; Allen & Meyer, 1990).

It was beneficial to fully understand what shaped the identity of newcomers to provide a forecast of adjustment and engagement with others inclusive of peers, superiors, and those served. Ashforth and Saks (1996) described the influence socialization has on role orientation and identification of newcomers and they adjust to the organization's mission. A coworker and supervisor involvement in the socialization of employees can make the difference between successful onboard and role identity and additional work stress and burnout (Babin & Boles, 1996; Shoji et al., 2016) and affect levels of self-efficacy and work engagement (Rogala et al., 2016).

Self-image and identity are shaped by onboarding processes that socialize employees to an organization. Saks and Ashforth (1997) and later, Perrot et al. (2014) argued newcomer orientation established and shaped the identity of the individual as a part of the organization. The researchers took different approaches to that end, with Saks and Ashforth (1997) focused on socialization tactics the organization used to socialize newcomers, how newcomers socialized themselves, and outcomes; while Perrot et al. (2014) addressed organizational socialization support and outcomes.

It is hypothesized organizations that invest in training to socialize and orient service providers would be trying to increase the magnitude of self-efficacy levels

(Gruman et al., 2006). Organization that serve veterans may benefit from ensuring training on military culture, to increase levels of self-efficacy (Nedegaard & Zwilling, 2017), are part of the formal or informal socialization (Jones, 1986), which may mitigate barriers previously identified by veterans; particularly those experiencing homelessness (Cretzmeyer et al., 2014). Perrot et al. (2014) cited the works of Ashforth and Saks (1996), Saks and Ashforth (1997), Cable and Parsons (2001), and Gruman et al. (2006), to present how socialization tactics impact perceived organizational support.

In western cultures, identified as the United Kingdom and Ireland, Europe, North America, which includes the United States and Canada, as well as Australia and New Zealand, social work evidence-based practices are influenced by organizational culture, beliefs, supervisors, and peers (Scurlock-Evans & Upton, 2015). There is no way for the characteristics of an organization to be absent of some level of impact on and shape the culture and behaviors of its staff, which was evidenced in Scurlock-Evans and Upton's (2015) meta-analysis that examined the training attendance of social workers and whether it offered evidence-based practices and organizational culture. The researchers found perception of organizational culture was a predictor of shaping social workers' attitudes and beliefs, as well as provided the ability to practice competent skills when supporting clients (Scurlock-Evans & Upton, 2015).

There was incongruence of whether evidence-based practices were beneficial and valued and contradictions in how it was defined, recommending exploration during future research (Scurlock-Evans & Upton, 2015). Skills, attitudes, and beliefs that center on practices to support clients and whether the organizational culture was supportive of

those attributes may be viewed as a strength or barrier (Consiglio, Borgogni, Di Tecco, & Schauefli, 2015; Perrot et al., 2014). Organizational culture was reinforced when staff was socialized to the organization and impacted the perceived support for persons served, which shaped those skills, attitudes, and beliefs of service providers, as well as perceived self-efficacy (Gruman et al., 2006; Perrot et al., 2014). This concept of socialization tactics supported the second research question in the examination of the relationship with levels of self-efficacy (Consiglio et al., 2015; Gruman et al., 2006; Jones, 1986).

Perrot et al. (2014) did not find a statistically significant relationship with socialization tactics when there was a lower level of perceived organizational support. Levels of organizational support were considered a challenge for the organization when an employee's innovation was contrary to the organization's mission or policies (Perrot et al., 2014). Based on those findings, it can be inferred that individuals who join organizations with veteran staff members with a self-reported high level of military cultural competence through having served, had exposure, or participated in training, or were socialized to increase levels of military culture competence, would be less likely to create barriers or have negative attitudes toward veterans experiencing homelessness. That was not to say individuals who had negative feelings or possessed a negative bias toward military service would change their beliefs through the socialization process, regardless of whether individualized or institutionalized tactics are employed (Perrot et al., 2014).

The intended ambiguity that sometimes existed in the organization's onboarding and socialization processes will affect employees differently (Kowtha, 2016; Perrot et al.,

2014). Kowtha (2016) argued tolerance of ambiguity moderates the effects and reiterate the findings of the effects of socialization tactics on role clarity, social integration, and organizational commitment. The study collected data from 233 Southeast Asia engineering and business graduates over a 6-month period (Kowtha, 2016). Even within a collectivistic society and the compulsory military service of Asian men, the researchers posited the difference in individuals were based on personalities, past experiences, and other attributes similar to the contextual framework of self-efficacy theory. Military exposure and veterans of military service have been the benefactors of institutionalized socialization or at least in that context when exposed to military culture; however, ambiguity was interwoven to offer different roles and military occupational specialties to close the loop on contextual socialization (Kowtha, 2016). It could be assumed that an employees' military cultural competence and increased levels of tolerance of ambiguity would be more flexible in their learning and orientation, as well as the need for structured processes (Kowtha, 2016). Closing the gap between ambiguity and intended formal procedures for newcomers improved the chance of remaining with organization more so than informal processes that lack structure (Kowtha, 2016).

Saks and Gruman (2018) found changes to an individual's engagement in their first year of employment and found a relationship between socialization tactics and changes in organizational outcomes. Pathways to organizational tactics have been developed to increase work engagement by reducing uncertainty of employees (Saks & Gruman, 2018). Previously Saks and Gruman (2011) didn't find a relationship between socialization and organizational outcomes; however, perceived self-efficacy from past

experiences was found to play a role in the how employee's engagement was shaped (Saks & Gruman, 2018). An organization's performance depends on attitudes, worth ethic, and engagement of employees depending on the social capital and work-related resources provided to employees after their entry (Saks & Gruman, 2018). Saks and Gruman challenged uncertainty reduction theory as basis for socialization tactics research, indicating its limitations in its application to newcomer engagement and offered a pathway to newcomer socialization. Measuring newcomer work engagement during the first year of employment may indicate whether socialization tactics are effective in increasing self-efficacy based on resources provided (Saks & Gruman, 2018).

Self-Efficacy

Self-efficacy pertains to an individual's perception of his/her ability to complete tasks related to their difficulty, prior performance, and experiences (Bandura, 1986; Bandura, 1993). Bandura (1993) posited cognitive, motivation, affective, and selective processes related to self-efficacy contributes to affect outcome levels and their respective charges (e.g., student, clients, customers, etc.). Hence, nonclinical nonmedical service providers supporting veterans experiencing or at risk for homelessness may fluctuate in self-efficacious thinking if they have limited military cultural competence or believe they are not able to relate to the veterans' self-regulatory factors; particularly when rules and processes are contrary to their beliefs. Capabilities and resources may be responsible for presenting unique challenges for service providers to exercise control over levels of perceived efficacy, particularly if the environment was not conducive to change

(Bandura, 1993). It was the culture of an organization that dictated whether change was possible or representative of status quo beliefs and behaviors.

Lunenburg (2011) posited three dimensions of self-efficacy as magnitude, strength, and generality according to Bandura's social cognitive theory that influences perception, motivation, and performance. Stajkovic and Luthans (1998) argued task complexity moderated the effect of self-efficacy on work performance by recommending a scale to measure predictors based on a multifaceted approach. A confirmation was presented by Lunenburg (2011), who more specifically argued self-efficacy influenced goals, learning, and attempts at new or difficult tasks, which were identified as Bandura's four sources of self-efficacy: past performance, vicarious experience, verbal persuasion, and emotional cues (Lunenburg, 2011). Lunenburg (2011) argued organizations can benefit from understanding the influence of self-efficacy and how it motivates employees in their performance, who attends training and development programs, and competitiveness in the workplace, to include how goals are set.

In taking a desensitization approach posited by Bandura and Adams (1977), when military cultural competence increased knowledge of veterans' issues desensitized effects to increase self-efficacy when serving veterans. Gountas, Gountas, and Mavondo (2014) argued organizational culture, coworker support, self-efficacy, job satisfaction, and customer orientation with higher levels of self-efficacy have lower needs of coworker support and less likely to rely on organizational resources. Length of time in current position or profession may also contribute to the levels of perceived self-efficacy of

service providers based on orientation to their role and adjustment to the organization (Jones, 1986).

Based on Nedegaard and Zwilling's (2017) argument and Bandura's (1993) self-efficacy theory, past experiences and military exposure influenced strategies and approach when dealing with veterans by either accepting and integrating beliefs about competency as associated with perceived self-efficacy and not military cultural competence. Hence, self-efficacious thinking of nonclinical nonmedical service providers, supporting veterans experiencing or at risk for homelessness, may fluctuate if they have limited military cultural competence or believe they are not able to relate to the veterans' self-regulatory factors; particularly when rules and processes are contrary to their beliefs Nedegaard & Zwilling, 2017).

Rogala et al. (2016) argued past performance, and social identity was not the only predictors of increasing, or declining self-efficacy, citing exhaustion and disengagement as predictors that affected ability and functioning levels. Self-efficacy theory was the platform used that further examined and similar to the statistically significant relationship that was found between self-efficacy and military cultural competence when serving military veterans (Meyer et al., 2015; Nedegaard & Zwilling, 2017).

Bresó, Schaufeli, and Salanova (2011) argued the premise of social cognitive theory applicable to an intervention to positively influence self-efficacy levels, increase engagement and performance, and reduce burn out of college students for three groups, intervened, stress-controlled, and healthy-controlled. The results were consistent with the assumptions that burnout and stress would be decreased for all groups; however, there

was no significant change to the group considered healthy-controlled at the onset of the study, at Time 1, or at Time 2. Two other groups, intervened and stress-controlled, were identified as having a statistically significant change for efficacy and performance but not burn out (Bresó et al., 2011). The implications of Bresó et al. were interventions that increased levels of self-efficacy which influenced engagement and can be inferred to purport increasing levels of self-efficacy of service providers supporting veterans experiencing homelessness influenced by increased engagement; therefore, reducing barriers to access and use of programs and services. However, the limitations related to generalization outside of a student population limits the applicability to service providers serving veterans, because the variability was explicitly contrary and did not account for personality, prosocial tendencies, or agreeableness.

It was Caprara, Sapienza, and Eisenberg's (2012) quantitative examination of agreeableness, transcendence values, and empathetic self-efficacy where they found the tendency to exhibit prosocial behaviors was contributed to traits, values, and self-efficacy beliefs. The researchers emphasized the inclination of people demonstrating behaviors that benefit others predicated by self-efficacy beliefs are judgments people hold about their ability to be successful (Caprara et al., 2012). Caprara et al. (2012) found that women scored higher than men at Time 1 and Time 2 on agreeableness, transcendence values, and empathetic self-efficacy. Environmental conditions and gender role socialization may contribute to these differences (Caprara et al., 2012). As Meyer et al. (2016) and Nedegaard and Zwilling (2017) also argued, females are more likely to serve

in human services and clinical professions; therefore, the comparability may be influenced by gender and gender role socialization (Caprara et al., 2012).

Consiglio et al., (2015) applied social cognitive theory to the study of employees in Italy participating in two questionnaires at Time 1 and Time 2, over a 3-year period. The researchers considered self-efficacy a predictor of work engagement and employee's perception of their performance three years later, confirming a mediating relationship between self-efficacy and work engagement (Consiglio et al., 2015). It was noted self-report as a limitation of the study as participants as human agents may not be able to control other people and environment, but they can control the circumstances of which they are affiliated with (Consiglio et al., 2015). This notion was especially important as it related to burnout and affecting performance. Human services professionals serving and engaging with veterans experiencing homelessness are at risk of decreased levels of self-efficacy if employees are not fully able to recognize the value in their performance or feel as though it matters (Bresó et al., 2011).

Web-Based Surveys

Kraut et al. (2004) argued the evolutionary advancement of the internet had offered access to a larger potential population sample through a less expensive means that also decreases the time needed to reach the demographic populations for target sample. Ansolabehere and Schaffner (2014) argued the cost and convenience of online surveys contributed to the attractiveness of its use but did not conclusively represent more accurate results or difference in conclusions when compared to mail or telephone interview. Though Nulty (2008) found a greater response rate among university students

when conducting face-to-face paper surveys, the researcher purported this action negates the benefits of using information technology.

Precontact, number of contacts, and personalized contacts have been found to contribute to increased response rates for internet surveys, with length, questions, and passwords were less important (Cook, Heath, & Thompson, 2000). However, Liu and Wronski (2017) presented Galesic and Bosnjak's (2009) findings of preannounced survey lengths had higher start, screening, and completion rates. Liu and Wronski found longer surveys with more words affect the completion rate, whether taking the survey was difficult, such as types and length of questions asked, and those without progress bars were factors. Open-ended questions are considered more difficult to complete in comparison to multiple-choice questions, considered simpler, as argued by Liu and Wronski (2017). Regarding the use of progress bars, there was less than .7% difference in having no progress bar to having a bar on top, with a 1.2% difference between bar on top and bottom (Liu & Wronski, 2017). There was only a 1.9% difference between no progress bar and bar at the bottom, though the lowest completion rate for a progress bar on the bottom was 85.6%, so the overall difference was relatively small (Liu & Wronski, 2017).

Another finding of interest was the consideration of introductions to the survey, which have been found to increase participation rates; however, it was posited by the researchers that individuals who are interested in a study might agree to participate and complete the survey, without an introduction (Liu & Wronski, 2017). One of the limitations reported, for this meta-analysis, was generalizability of completion rates and

web survey results outside of the United States, with different cultures and languages and need for surveys to reflect day-to-day survey taking, not just the methodologies presented by subject matter experts (Liu & Wronski, 2017). Attention had been given to method of participant contact, length of the survey, and completion rates when the type of scale was considered for this study when I utilized a cross-sectional web-based survey.

In addition to how participants are contacted and the length of the survey, expectations of privacy and confidentiality concerns of participants must be considered, and ethical action taken for protection. Buchanan and Hvizdak (2009) argued the need for protocols to address protection against spam, location of data and identifiable information of respondents on the server, and how respondents are informed of the lack of absolute privacy of internet sites as factors that must be articulated to the Institution Review Board for protection of participants and integrity of data.

Ramsey, Thompson, McKenzie, and Rosenbaum (2016) argued the appropriateness of web-based surveys and found no limitations to its use for recruitment and survey administration with the caution of providing adequate instructions but did not offer valid or tested models to increase response rates, which impact effect. Evans and Mathur (2005) maintained the strengths of web-based surveys include elimination of paper, providing a global reach, ease of data entry and analysis, and flexibility. The meta-analysis offered comparison of the strengths and weaknesses of mail, web, and telephone interviews (Evans & Mathur, 2005). Evans and Mathur argued the need to give respondents the opportunity to opt-out of the study, have the ability to direct respondents to the uniform record locator (URL), offered pop-up windows with

instructions, and make policies visible and respondent-friendly to moderate the weaknesses of web-based surveys. Given consideration of the strengths, weaknesses, and expected completion rates, I deduced a cross-sectional web-based survey was appropriate for this study.

Summary and Conclusions

It may be assumed by virtue of having served in the military, regardless of branch of service, there was a connection, camaraderie; however, the subcultures that exist do not guarantee the ability to relate to veterans experiencing homelessness (Meyer, 2013; Meyer et al., 2015; Nedegaard & Zwilling, 2017). Homeless plight in the United States was similar, compared to the countries of allied armed forces, but have distinct differences in the approaches to respond to this crisis. The literature review I conducted yielded a plethora of references related to the concept of cultural competence and self-efficacy with limited studies dedicated to specifically addressing military cultural competence outside of the context of physical or mental health and clinical care. There was a confirmed gap in the literature associated with how nonmedical nonclinical service providers relate to veterans experiencing homelessness and whether barriers to access and use of programs and services exist due to engagement with these service providers (Knecht & Martinez, 2012; O'Connell et al., 2008). Most of the studies tied to military cultural competence and levels of perceived self-efficacy were undertaken in health care settings, such as with social workers, therapists, and nurses, and I concluded that nonclinical, nonmedical service providers who serve veterans experiencing homelessness

was not addressed (Cheney et al., 2018; Creamer et al., 1999; Cretzmeyer et al., 2014; Fox et al., 2016; Matarazzo et al., 2015; Tanielian et al., 2016).

Socialization tactics have also been examined with graduates from business schools and nonhuman services organizations. Researchers have taken different approaches to socialization tactics and employee role orientation (Allen & Meyer, 1990; Jones, 1986) but have not been examined organizations that serve the homeless population. Homeless individuals have reported negative treatment from service providers but there are limited qualitative, quantitative, or mixed methods approaches that have explored, examined, or analyzed factors that discussed whether levels of self-efficacy of nonmedical, nonclinical service providers impacted the outcomes or affected the population of veterans experiencing homelessness. Both socialization tactics and levels of military cultural competence have been associated with levels of perceived self-efficacy, but neither has been reviewed in the context of socialization tactics as a moderator or influencing that relationship. Additionally, studies have included clinical or health care professionals and their interaction with patients or individuals experiencing homelessness. These studies have included attitudes and behaviors that created barriers to access and use of programs and services but have not focused on this phenomenon when examining interaction and engagement with nonmedical nonclinical service providers.

The need for this study increased when I found the literature was limited in examining the nonmedical nonclinical service providers of member organizations that serve veterans experiencing or at risk for homelessness that are associated with the CoC

Programs of each state. The literature supported the need for an understanding of the levels of perceived self-efficacy of nonmilitary service providers and the association with client outcomes. The results of this study may come closer to addressing the gap in the literature and add to the conversation of cultural competency curriculum in human service and nonmedical personnel training and education, as well as organizations' socialization of its employees.

After reviewing the literature, I concluded that a quantitative cross-sectional study utilizing a web-based survey to examine the relationship of military cultural competence with perceived self-efficacy and whether socialization moderates that relationship was the most appropriate methodology to examine this phenomenon. Chapter 3 provides further review of the study's sample population, sampling methods, research question and hypotheses, and use of a web-based survey. The chapter also provides information related to the proposed multiple regression and moderation analysis as an explanation and support for the methodology of this study.

Chapter 3: Research Method

Introduction

The purpose of this quantitative cross-sectional study was to examine the relationship between socialization tactics, military cultural competence levels, and self-efficacy levels of nonmedical nonclinical service providers employed with CoC Program member organizations. I also examined whether socialization tactics moderated the relationship between the levels of military cultural competence on levels of perceived self-efficacy. In this chapter, I describe the research design and rationale that established the research questions and appropriateness of study. I also provide an overview of the methodology, threats to validity, and ethical concerns, and the chapter concludes with a summary of the research method.

Research Design and Rationale

Examined variables of this quantitative study were: (a) military cultural competence (X), independent/predictor variable; (b) socialization tactics (M), independent/moderating variable; and (c) perceived self-efficacy (Y), dependent/outcome variable. I expected to discern the levels of military competence and levels of perceived self-efficacy based on responses to applicable statements. The responses also provided data to support agreement to statements related to socialization tactics used by the organization.

Methodology

Population

The target population of this study was adult nonmedical, nonclinical service providers employed with CoC Program member organizations in the three Southeastern states of Georgia, North Carolina, and South Carolina. These individuals were not identified as a vulnerable population and had to be able to agree to participate. I recruited potential participants from the available population of member organization employees from the 25 CoC Programs in the 3-state area (9 in Georgia; 12 in North Carolina; and 4 in South Carolina) serving 2,681 veterans of the total 27,519 reported homeless in 2016 (HUD, 2016). The disciplines and roles of the service providers included but were not limited to administrative, reception or scheduling staff, nonmedical nonclinical case managers, volunteer coordinators and volunteers, clergy or religious assistants, emergency shelter workers, human services workers and interns, lending locker and food bank staff, and teachers/educators.

Sampling and Sampling Procedures

The study was delimited to nonmedical nonclinical service providers who were employees of CoC Program member organizations, at least 18 years old, who had been with the organization no less than 4 months and preferably less than 18 months. A nonprobability, nonrandom convenience sampling did not give all participants who met the criteria an equal chance of inclusion (see Etikan et al., 2016). Convenience sampling was most appropriate because potential participants could not be contacted directly. Inclusion and exclusion criteria were presented as part of the study instructions that

facilitated the participation of a homogenous population (Gelo, Braakman, & Benetka, 2008; Hoyle & Smith, 1994). The CoC Programs' POCs were included in an online list for the target area, along with published online meeting minutes for many of the member organizations; however, the lists did not contain contact information for all employees or provide access to an employee database. This inconsistency of contact information affected my ability to make direct contact with the member organization POCs or the service providers who were the ultimate targets of inquiry, which may, in turn, have affected the sample size. With these limitations considered, all participants who volunteered to participate and confirmed they met the inclusion criteria were accepted. There was no other known timely and affordable method to recruit participants in a geographically dispersed region with the varying nature of the CoC member organizations.

I utilized G*Power 3 (Faul et al., 2007) with calculations based on the power of .80, the effect size of .15, and alpha of .05, which resulted in an estimated sample size of 68 when proposing to use two-tailed, linear multiple regression analysis with two predictors. The limitations related to attaining the appropriate estimated sample size were monitored throughout the recruitment process. I explicitly provided instructions when I identified the eligibility criteria for participation in the study.

Procedures for Recruitment, Participation, and Data Collection

I sent an e-mail to CoC Program POCs identified on the HUD (2016) website to garner support to disseminate recruitment materials. I sent a follow-up e-mail to POCs who had not responded after 3 weeks. Ten CoC Program POCs responded with letters of

cooperation, pledged to disseminate recruitment materials to staff employed with member organizations or agreed to publish study information in the CoC Program newsletter. COC Program POCs also had the option of sharing hardcopy recruitment materials such as the postcard-sized flyer that contained survey information and URL link during CoC Program monthly or bimonthly meetings or via e-mail.

This method of recruitment did not afford me with the ability to confirm participants had met the inclusion criteria; however, instructions in the online consent form identified the opportunity for potential participants to self-affirm eligibility based on stated inclusion criteria. Participants who were provided the recruitment materials to access the online survey by the POC from their organization were anonymous because the POC was not aware of an individual accessing the link or completing the survey unless the employee shared their participation.

I collected responses from the cross-sectional web survey that was available for more than the proposed 3-week period, which commenced the day after Walden Institutional Review Board (IRB) approval (# 09-13-18-0093646). When potential participants accessed the survey link, they were immediately provided with information related to the study and were asked to acknowledge understanding of potential risks, willingness to proceed, confirmation of meeting inclusion criteria, and agreement to participate through online informed consent before they were given access to complete the survey. The web-based survey included demographic questions and statements relating to military cultural competence, socialization tactics, and self-efficacy. Participants did not have the opportunity to save the survey before completion to return,

as there were no internet protocols or e-mail addresses collected to reroute them back to the survey. After completing the survey, participants were thanked for their participation and then exited from the survey. Individuals who selected disqualifying responses were routed to a custom disqualification page and thanked for their participation.

Instrumentation/Operationalization of Constructs

I collected cross-sectional data via demographic information and responses to the web-based version of the two assessment scales, the MCCP (Nedegaard & Zwilling, 2017) and the Socialization Tactics (Jones, 1986) via SurveyMonkey (2014b). Participants provided responses related to the research variables military cultural competence, socialization tactics, and perceived self-efficacy. I used the data collected through the surveys to test the hypotheses.

Demographics. Participants completed a 5-item demographic questionnaire. Questions were related to their age, gender, and position in their workplace. Two of the questions also referred to having experience working with veterans. As an example of a question related to their position, participants were asked, "To what extent do you or have you worked with veterans and their families?" I followed the demographic questionnaire with Nedegaard and Zwilling's (2017) MCCP assessment scale that measured responses to military cultural competence statements related to knowledge and awareness.

Military cultural competence. The initial section of Nedegaard and Zwilling's (2017) MCCP assessment scale contains nine statements related to military cultural competence. The statements solicited self-reported responses about the participant's ability to understand the culture of the military, specific conditions related to this

population, and perceived competencies needed to provide services to veterans and their families. This section was estimated to take approximately 5 minutes for respondents to complete.

Permission was granted by lead researcher, Dr. Nedegaard, for the use and republishing of the MCCP assessment scale (Nedegaard & Zwilling, 2017) via e-mail provided in Appendix A. The MCCP instrument (Nedegaard & Zwilling, 2017), was used to measure military cultural competence with a 6-point Likert-scale (1 = Strongly disagree to 6 = Strongly agree). Nedegaard and Zwilling (2017) developed the scale to assess self-report of service providers supporting military veterans, specifically the Army National Guard, offered in a knowledge acquisition model of pretest, training, and posttest format. A knowledge acquisition model was not followed as a strategy, in this study. Statements such as, "I am well versed in the language and acronyms commonly used in the military" and "I can fully appreciate what it is like to be deployed or have a family member deployed" were used to solicit respondent's level of agreement with each statement. After exploratory factor analysis, Nedegaard and Zwilling (2017) found the instrument reliability was high with Cronbach's alpha 0.958, for the Knowledge and Awareness sections. Higher summed scores (4–6) represent higher levels of military cultural competence, with lower scores representing lower levels.

Socialization tactics. An organization's approach to onboarding and training employees establishes role identity and strategies to acclimate employees to the organization's processes are considered socialization tactics. Jones's (1986) Socialization Tactics six 5-item (30-item) scale was used to examine the respondents'

self-report of their organization's use of socialization tactics, which was estimated to take approximately 10 minutes to complete. The Academy of Management maintains the rights for the scale and authorized blanket permission for use to students conducting dissertation studies (provided in Appendix C). The domains of the scale and examples of statements include: (from collective versus individual domain) "This organization puts all newcomers through the same set of learning experiences"; (from the formal versus informal domain) "I have been very aware that I am seen as "learning the ropes" in the organization"; (from the investiture versus divestiture domain) "Almost all of my colleagues have been supportive of me personally; (from the sequential versus random domain) "The steps in the career ladder are clearly specific in this organization"; (from the serial versus disjunctive domain) "I have been generally left alone to discover what my role should be in this organization" (reverse scored); and (from the fixed versus variable domain) "I can predict my future career path in this organization by observing other people's experience" (Jones, 1986). Jones (1986) used the scale to collect data from graduating Master of Business Administration students at two points: before accepting a job and after five months on the job. The scale was measured with a 7-point Likert-type scale (1 = Strongly disagree to 7 = strongly agree), and reliability of the domains was in the range of 0.68 to .084 (Jones, 1986); though, collapsing the dimensions into one factor for analysis yielded reliability of alpha 0.84 (Gruman et al., 2006). When collapsing the domains scores into one factor, the scores were summed and averaged with lower scores representing individualized socialization tactics and higher

scores representing institutionalized socialization tactics (Ashforth & Saks, 1996). Also, worth noting, Jones identified several items within the scale was reversed scored.

Perceived self-efficacy. Seventeen items on the MCCP assessment scale (Nedegaard & Zwilling, 2017) examined the self-report of self-efficacy, defined as the ability to complete difficult task or goals with positive outcomes (Bandura, 1993). It was estimated to take approximatel10 minutes for respondents to complete. Items are measured by selecting a response on a scale of 0–100 (Nedegaard & Zwilling, 2017). Items are summed and averaged to establish the levels of self-efficacy, with lower scores (0–40) representing lower levels (cannot do at all), moderate scores (41–79) for moderate levels (moderately can do), and higher scores (80–100) representing high levels (highly certain can do) (Nedegaard & Zwilling, 2017). Respondents' degree of confidence was measured on this scale based on statements, such as to what degree they believe they can "Show empathy toward a veteran and their family," "Understand the special issues that veterans and their families have," and "Demonstrate attentive and supportive verbal communication with veterans." Similar to Knowledge and Awareness in measuring military cultural competence, the reliability was established for the Confidences in Abilities/Abilities section, relating to self-efficacy, at a high of 0.943 (Nedegaard & Zwilling, 2017). After descriptive analysis, skewness was identified at 0.266 and a kurtosis at 0.526 (Nedegaard & Zwilling, 2017).

Data Analysis Plan

After collecting data from participants, I reviewed and scrubbed the data to identify missing data, conflicting responses, abnormalities, and outliers, as described by

Duffy (2006) and Farrokhi and Mahmoudi-Hamidabad (2012). Duffy argued that power could be directly affected if too much data was missing from a data set; particularly on key variables, while Collins, Schafer, and Kam (2001) offered caution about the potential inflation of Type I and Type II errors. Baraldi and Enders (2010), followed the works of Shafer and Olsen (1998) and provided resolution of missing data can be achieved through multiple imputation regression methods; however, multiple imputation was not run for this study as preliminary data analysis because no data was missing from the final cases.

As recommended by Baraldi and Enders (2010), surveys with unresolved missing data were deleted and not included in the study. When Zhang and Wang (2017) compared moderation analysis with missing data on the predictor variable, in a simulated study design, the researchers found biased estimates of the effects; though, there was a difference with large sample sizes. In that respect, failure to delete surveys with missing data would have impacted the effect size and potentially lead to Type I errors (Collins et al., 2001; Duffy, 2006; Shafer & Olsen, 1998). Baraldi and Enders shared that deleting surveys limited available data for analysis, decreased the sample size, and could have created an under or over representation of the sample. With that caution, a thorough review of all cases was conducted to maximize the use of all available data to maintain effect size.

Also, a possible mitigating strategy to limit missing data was presented by Gwaltney, Shields, and Shiffman (2008) and Wright (2017), which illuminated a required response feature offered by software packages, such as SurveyMonkey, which forces the respondent to record a response to the survey item before moving forward in the survey.

I utilized the required response strategy, defined as logic, which prevented respondents from discontinuing the survey if not willing to answer a particular question and also prompted respondents to revisit any overlooked survey items. Using the logic feature mitigated some of the risks of missing data. It was after resolving any issues identified with the data (i.e., missing data, abnormalities, and outliers, etc.), I tested the hypotheses with SPSS version 25.

Research Questions and Hypotheses

RQ1: What is the relationship between levels of military cultural competence and levels of perceived self-efficacy of nonmedical nonclinical service providers employed with CoC Program member organizations who serve veterans experiencing homelessness?

$H_0$1: There is no statistically significant relationship between levels of military cultural competence and levels of perceived self-efficacy of nonmedical nonclinical service providers employed with CoC Program member organizations who serve veterans experiencing homelessness.

H_a1: There is a statistically significant relationship between levels of military cultural competence and levels of perceived self-efficacy of nonmedical nonclinical service providers employed with CoC program member organizations, who serve veterans experiencing homelessness.

RQ2: What is the relationship between socialization tactics and levels of perceived self-efficacy of nonmedical nonclinical service providers employed

with CoC program member organizations who serve veterans experiencing homelessness?

$H_0$2: There is no statistically significant relationship between socialization tactics and levels of perceived self-efficacy of nonmedical nonclinical service providers employed with CoC Program member organizations who serve veterans experiencing homelessness.

H_a2: There is a statistically significant relationship between socialization tactics and levels of perceived self-efficacy of nonmedical nonclinical service providers employed with CoC Program member organizations who serve veterans experiencing homelessness.

RQ3: What is the relationship between levels of military cultural competence and socialization tactics of nonmedical nonclinical service providers employed with CoC Program member organizations who serve veterans experiencing homelessness?

$H_0$3: There is no statistically significant relationship between levels of military cultural competence and individualized versus institutionalized socialization tactics of nonmedical nonclinical service providers employed with CoC Program member organizations who serve veterans experiencing homelessness.

H_a3: There is a statistically significant relationship between levels of military cultural competence and individualized versus institutionalized socialization tactics of nonmedical nonclinical service providers employed with CoC

Program member organizations who serve veterans experiencing homelessness.

RQ4: What is the relationship between levels of military cultural competence on levels of perceived self-efficacy when socialization tactics are used by CoC Program member organizations when onboarding nonmedical nonclinical service providers who serve veterans experiencing homelessness?

$H_0$4: There is no statistically significant relationship between levels of military cultural competence on levels of perceived self-efficacy when socialization tactics are used by CoC Program member organizations when onboarding nonmedical nonclinical service providers who serve veterans experiencing homelessness.

H_a4a: There is a statistically significant relationship between high levels of military cultural competence and high levels of perceived self-efficacy when socialization tactics are used by CoC Program member organizations when onboarding nonmedical nonclinical service providers who serve veterans experiencing homelessness.

H_a4b: There is a statistically significant relationship between high levels of military cultural competence and low levels of perceived self-efficacy when socialization tactics are used by CoC Program member organizations when onboarding nonmedical nonclinical service providers who serve veterans experiencing homelessness.

H_a4c: There is a statistically significant relationship between low levels of military cultural competence and high levels of perceived self-efficacy when CoC Program member organizations use socialization tactics when onboarding nonmedical nonclinical service providers who serve veterans experiencing homelessness.

H_a4d: There is a statistically significant relationship between low levels of military cultural competence and low levels of perceived self-efficacy when CoC Program member organizations use socialization tactics when onboarding nonmedical nonclinical service providers who serve veterans experiencing homelessness.

I utilized bivariate correlations and two-tailed multiple regression analysis to address the research questions and test the hypotheses that examined whether there was a predictive relationship between levels of military cultural competence and levels of perceived self-efficacy, as well as between socialization tactics and levels of perceived self-efficacy of nonmedical nonclinical service providers employed with CoC Program member organizations who serve veterans experiencing homelessness. Bivariate correlation was conducted to examine whether there was a relationship between levels of military cultural competence and socialization tactics. Multiple regression was also be conducted for moderation analysis to examine whether there was a statistically significant relationship between the interaction between socialization tactics and levels of military cultural competence on levels of perceived self-efficacy.

According to Baron and Kenny (1986), MacKinnon (2011), and Hayes and Rockwood (2017), moderation is the effect of different levels or values of the moderating variable, examining when the effect may occur and under what circumstances. Moderation analysis is appropriate for both experimental and nonexperimental designs when attempting to provide evidence of plausibility (MacKinnon, 2011; Roeder et al., 2014). This effect is also considered beneficial for organizational research when attempting to explain associations (Wei, Heppner, Ku, & Liao, 2010).

The effect of a third variable's relationship was between the independent and outcome variable (MacKinnon, 2011). It was Baron and Kenny (1986) who argued pathways between independent and dependent variables demonstrated how and why the change occurred versus when effects hold, which clarified and accounted for differences in behaviors. The function of the third variable was to examine whether it served as a moderator influencing the dependent variable (Baron & Kenny, 1986).

I used the steps presented by Baron and Kenny (1986), as well as Diebold (2013), in this study. Diebold described processes that required bivariate correlations of the independent variable on the dependent variable for correlation and statistically significant relationships, as well as examining the correlation between the independent variable and the other independent variable, acting as the possible a moderator. To address multicollinearity, it was also recommended to center the independent variable and moderator to produce a centered version of the two variables for analysis, which should cause the variable mean to become one (Baron & Kenny, 1986; Diebold, 2013). Descriptive statistics provided the minimum, maximum, mean, and standard deviation for

each variable (Diebold, 2013). Once the mean was identified, it was then possible to create the formula to compute the centered variables by subtracting the mean (Diebold, 2013). The next step was to multiply the centered independent variable and centered moderation variable to create the interaction term (Baron & Kenny, 1986). Then regression was tested by utilizing the centered variables and the interaction terms (Diebold, 2013). Diebold (2013) confirmed Baron and Kenny's (1986) rationale for four sets of hypotheses in moderation analysis: 1) regression of each independent variable and outcome variable; 2) regression of independent variable and moderator; 3) interaction, and 4) combined effect. In addition to the statistical tests of multiple regression, tests of assumption must also be performed (Antonakis & Dietz, 2011). The statistical results of the analysis provided the evidence to accept or reject the null hypotheses related to the study.

Threats to Validity

External Validity

Convenience sampling was identified as an external threat to validity (Etikan et al., 2016). Nonrandom sampling could cause a threat to generalizability beyond the characteristics of the participant sample, as the results are not generalizable across populations that are not identical to the participant sample (Campbell & Stanley, 1963; Etikan et al., 2016; Onwuegbuzie, 2000). Convenience sampling was considered a threat to not only experimental and quasi-experimental studies (Campbell & Stanley, 1963), but Onwuegbuzie (2000) argued the inability to replicate a nonexperimental study when using a nonrandom sample presents the same threat. Etikan et al. (2016) argued

convenience sampling affects the ability to draw inferences, as bias and outliers may exist when participants self-select and self-report when responding to surveys. External threats were assessed throughout the process of data collection, analysis, and interpretation (Onwuegbuzie, 2000). For this study, the threats were handled by describing the effect and limitations of using convenience sampling as part of the discussion and conclusion of the study.

Internal Validity

Campbell and Stanley (1963) identified the threats to internal validity as history, maturation, testing, instrumentation, statistical regression, differential selection of participants, mortality, and interaction effects. The specific threats to internal validity of importance for this study are instrumentation, selection of participants, and interaction effects.

Jones's (1986) study presented values that confirm validity and reliability for the Socialization Tactics assessment scale, which was replicated by Saks and Ashforth (1997), but the age of the instrument could affect validity (Campbell & Stanley, 1963). Conversely, recent studies utilizing the Socialization Tactics scale, either in totality or in part, offered validity and reliability confirmation (Allen & Meyer, 1990; Ashforth & Saks, 1996; Cable & Parsons, 2001; Cooper-Thomas & Anderson, 2002; Saks & Ashforth, 1997). Gruman et al. (2006) modified the instrument by collapsing the domains of Jones's (1986) Socialization Tactics scale into one factor, as I proposed in this study. In the study of Gruman et al. (2006), it yielded an alpha of 0.84.

Another consideration of the threat to internal validity of the instrument was related to word choice of statements, which may differ in understanding or context from 1986 to current times and environment of study participants (Aitchison, 2005). Also, the use of nonrandom sampling in this study could introduce potential bias because the participants may self-select based on unidentified motives, unexplained intent, or social desirability (Campbell & Stanley, 1963; Fang et al., 2014; McKibben & Silvia, 2015). Self-reporting and recollection must be factored as a threat to internal validity because the responses may be biased (Krumpal, 2013). Other threats to internal validity exist when interaction effect of the variables measured have more than one explanation of the results or conflict in the explanation, particularly when trying to establish a causal relationship between the dependent and independent variables (Onwuegbuzie, 2000). These threats were addressed by testing the reliability and validity of results when describing the results, limitations, and conclusions of the study.

Construct Validity

After structural validity is confirmed, construct validity can be accomplished by assessing whether the theory supports the constructs or variables (Gelo et al., 2008; Hoyle & Smith, 1994). The instrument should pass construct validity in that it measures what it was intended to measure, that it was structurally sound, and the responses fit within the construct being measured (Hutchinson, 1999; Rachmatullah, Octavianda, Ha, Rustaman, & Diana, 2017; Ray-Murkherjee et al., 2014). Nedegaard and Zwilling (2017) cited a lack of convergent and discriminant validity requiring additional validation; however, the constructs were measured as intended. There was a tolerable level of

discriminant validity and higher convergent validity between the domain items of the Socialization Tactics assessment scale, with several factors correlated when loaded on one factor (Jones, 1986).

Ethical Procedures

Participants were recruited via recruitment materials and self-selection for participation. There was no direct contact with potential participants, which promoted privacy and confidentiality. Walden University IRB approval was requested at the appropriate phase of the dissertation process to receive approval before disseminating web-based survey link or collecting data. Recruitment materials contain no biased language and provided inclusion and exclusion criteria, IRB approval, as well as contact information for researcher and Walden University supervising faculty to promote transparency and mitigate other issues related to study instructions or participation. CoC Program POCs disseminated recruitment materials to the available pool. There were no known conflicts of interest between the researcher and potential participants. Also, no compensation or reimbursement was offered for participation.

There are no known psychological effects, legal or economic impacts, physical threats, or other risks associated with participating in this study that would not be expected to be experienced in everyday life. Information provided to the participants states the ability to withdraw, without penalty, at any point in the survey. Participants were provided a statement to call 911 if they experience a medical emergency or call 211, to reach local resources if they experience negative effects from participating in the survey.

Implied consent was received when participants accessed the web-based survey link that took them to the online SurveyMonkey (2014a) site. SurveyMonkey (Heen, Lieberman, & Miethe, 2014; Varela et al., 2016) is a vendor for web-based surveys that were used to collect data for this online cross-sectional survey. All survey data was transmitted in an anonymous encrypted format. E-mail and internet protocol addresses were not known to the researcher and were not collected by the third-party survey site (SurveyMonkey, 2013, 2014b).

Once survey data was downloaded on the personal computer of the researcher, hard copies were printed, and the data was electronically saved to DVD-Rs and password protection. Hard copy data and password-protected DVD-Rs were in possession of the researcher when not in a locked file cabinet and will not be shared with anyone except supervising faculty members. I have not used any personally identifiable information for any purpose outside of research, and there were no research assistants, transcribers, or statisticians who had access to the data. As required by Walden University, data will be kept for at least five years in a secure password-protected external drive (DVD-Rs), which is housed in a locked file cabinet in my locked home office and accessible only to me.

Participants were provided with the contact information of the Walden University supervising faculty member, and University Advocate and me to facilitate contact if there are any questions related to the survey or if they would like to receive a copy of the summary of results when completed. If participants selected a disqualifying response, they were directed to a custom message to thank them for their willingness to participate

and advise them of their disqualification due to their response. Participants who completed the web-based survey, in its entirety, received a message to thank them for their participation.

Summary

A quantitative cross-sectional study was the most appropriate method to examine whether there was a statistically significant relationship between socialization tactics, military cultural competence levels, and perceived self-efficacy levels of service providers employed with CoC Program member organizations, supporting veterans experiencing homelessness. Statistical tests were also conducted to determine whether socialization tactics moderates the relationship between military cultural competence levels and perceived self-efficacy levels. A cross-sectional online survey was the most cost-effective and efficient tool to gather responses from participants located in a 3-state area. Ethical responsibility requires the protection of the confidentiality and privacy of participant information, integrity of the data collected and paying attention to the treatment of human participants. Information related to IRB approval, unforeseen changes to the proposed plan, data collection, data analysis, and study conclusions, along with applicable figures and tables are presented in Chapter 4. Interpretation of the results of the study, limitations, recommendations, as well as future research and practical implications, are included in Chapter 5.

Chapter 4: Results

Introduction

The purpose of this quantitative cross-sectional study was to examine whether there was a statistically significant relationship between levels of military cultural competence, socialization tactics, and levels of perceived self-efficacy of service providers employed with CoC Program member organizations who serve veterans experiencing homelessness. The research questions and hypotheses centered on whether statistically significant relationships existed between the independent variables, levels of military cultural competence and socialization tactics, and the dependent variable, levels of perceived self-efficacy. The study also examined whether socialization tactics moderated the relationship between levels of military cultural competence on levels of perceived self-efficacy.

In this chapter I offer the results of this study and discuss the data collection procedures. The data collection section is followed by a description of the characteristics of the final sample, which includes representation percentiles. I present subsections such as data preparation and statistical tests for assumptions of multiple regression as a precursor to the following section that includes the statistical analysis and results. I found the results of this study corroborated the findings of previous literature in that positive and significant relationships exists between levels of military cultural competence, socialization tactics, and levels of perceived self-efficacy. The chapter concludes with a summary of the analyzed results, discussion, and tables.

Data Collection

Walden University IRB approval was received on September 13, 2018, and the web-based cross-sectional survey was made available on SurveyMonkey the following day, September 14, 2018. However, the collection of responses was postponed due to the imminent threat of a significant natural disaster in mid-September 2018, Hurricane Florence. This tropical storm turned hurricane subsequently affected the 3-state geographic region of Georgia, North Carolina, and South Carolina. The survey launch delay was to demonstrate consideration for potential participants who may have experienced devastation.

I notified twenty-five COC Program POCs on September 19, 2018, of the survey availability and provided recruitment materials to begin the data collection. Review of survey responses one week before the proposed closure did not yield an adequate estimated sample size ($n = 21$), so the survey was extended for an additional two weeks. The COC Program POCs were notified via e-mail of the extension and encouraged to resend link and flyer to potential participants as a consideration for those potential participants in confirmed affected areas of South Carolina and North Carolina who did not receive the follow up e-mail. Immediately after the notification was sent, another storm was predicted for the same region, Hurricane Michael, which caused further delay in closing the survey and prompted another e-mail to COC Program POCs. The survey eventually closed on November 12, 2018, 12:01 AM. It was confirmed before closure that an adequate number of completed survey responses had been received.

E-mails were sent to a total of 38 CoC Program POCs and 87 individuals responded to the survey, which represented a 3% response rate of the targeted sample of approximately 2,500. Even with the small response rate, an adequate sample of at least 68 provided an adequate effect size. Four respondents (5% of total) did not meet the criteria of at least 4 months and less than 18 months or were not an employee of a CoC Program member organization; therefore, they were disqualified, leaving a total of 83 respondents for further consideration. The logic feature available in SurveyMonkey was used when I built the online web-survey. Logic required participants to respond to each of the survey questions, except for demographic characteristics. Also, when a respondent answered with a response that disqualified them from the study pool based on the delimitation criteria, participants were redirected to a custom disqualification page that thanked them for their participation. The internal survey logic functionality prevented them from continuing to the subscales of military cultural competence, socialization tactics, and perceived self-efficacy.

Thirteen (19% of remaining 83) respondents provided informed consent and completed the demographics portion of the survey before being disqualified due to one or more of their responses, which left a potential pool of 70 (85% of remaining 83) respondents. Two additional respondents were disqualified due to reporting not currently or ever having served veterans and a neighbor/friend of a veteran, which left 68 (81% of remaining 83) individuals as participants, whose responses were used to conduct further analysis.

The data collection process was not completed according to the plan presented in Chapter 3, noting the caveat of the extended survey period due to hurricanes in the targeted 3-state region. After survey closure, data was downloaded from SurveyMonkey and screened for missing data. I removed all surveys that included missing data before further analysis. I summed and averaged values for independent and dependent variables to establish new variables for further analysis in the Statistical Package for the Social Sciences (SPSS) version 25. I conducted descriptive and frequency analysis and confirmed there was no missing data. I present the results of the analysis in the next section.

Results

Descriptive Statistics

The targeted population for this study was delimited to nonmedical nonclinical service providers employed with CoC Program member organizations who were at least 18 years old. Eligible service providers were employed no less than 4 months and preferably less than 18 months. The targeted geographical location was the southeastern states of Georgia, North Carolina, and South Carolina. Demographic information is presented in Table 1, of which the sample population included 44 females (60.95%) and 27 males (39.1%). The largest percentage of participants self-reported within the age range of 35-44 (n = 25, 36.8%). Approximately 52% (n = 35) of the respondents reported having never served in the military or being the spouse of someone who had served. Professional affiliation most represented was in the category of volunteer coordinator/volunteer (35.3%, n = 24) and in the subcategory outreach (11.8%, n = 8). It

can be assumed many of the nonprofit organizations hosting events on or near Veterans Day (November 11) may have contributed to the large number of volunteer coordinators/volunteers responding to the recruitment invitation. Many of the participants (52.9%, $n = 36$) reported "occasionally" as the extent of currently serving or having previously served veterans in the category of "helping with veterans' benefits" (26.5%, $n = 18$). Categories of "nonmedical nonclinical case manager" and "providing information and referral" were both represented in 11.8% of the responses ($n = 8$).

Table 1

Demographic Characteristics of Study Participants

Characteristic	*N*	Percent
Gender		
Female	41	60
Male	27	40
Age		
25-34	11	16
35-44	25	37
45-54	16	24
55-64	16	24
Professional affiliation		
Volunteer coordinator/volunteer	24	35
Human services worker/case manager (nonclinical/nonmedical)	21	31
Other	15	22
Shelter worker	5	7
Pastor/clergy	2	3
Teacher/instructor	1	2
Veteran or spouse of veteran		
No	35	51
Yes	33	49
Extent work with veterans		
Occasionally	36	53
Often	15	22
Extensively	11	16
Rarely	6	9
How have worked with veterans		
Other	20	40
Helped with veterans' benefits	18	27
Participated in fundraising/community service Project	14	21
Served as nonmedical nonclinical case manager	8	12
Provided information and referral	8	12

Note. $n = 68$. *Percent values were rounded.

After running the frequency analysis and removing all cases where respondents provided disqualifying responses, no cases were remaining with missing data. Because there was no missing data, I moved to the next step of analyzing the data to evaluate the reliability of the scale used in the study. Reliability for each subscale was assessed for each variable (Table 2).

Table 2

Descriptive Statistics and Reliability Analysis of the Military Cultural Competence, Socialization Tactics, and Perceived Self-Efficacy

	Military cultural competence	Socialization tactics	Perceived self-efficacy
Possible range	1 – 6	1 – 6	1 – 100
Mean	4.17	4.30	69.76
Std. error	2.21	.15	.12
SD	1.22	.99	18.20
Minimum	1	2	29
Range	5	4	71
Maximum	6	6	100
Skewness	-.06	-.13	-.10
Kurtosis	-1.11	-1.28	-.96
Cronbach's α	0.97	0.97	0.962

Note. Percent values were rounded to .00.

As presented in Table 2, the mean scores for levels of military cultural competence ($\bar{x} = 4.17$) was in the range that indicated neither lower nor higher levels. The mean scores for socialization tactics ($\bar{x}$ = 4.30) was in the range that indicated neither more institutionalized nor individualized socialization tactics. Levels of

perceived self-efficacy mean score was $\bar{x}$ = 69.76, representing the "moderately can do" range.

Also represented in Table 2, results of skewness are reported as (α_3 = -.06), (α_3 = -.13), and (α_3 = -.10), indicating the data set is more left of the mean than right. For kurtosis, the (α_4 = -.1.11), (α_4 = -1.28), and (α_4 = -.96), all considered to the left of the mean, indicate the assumption for normality is violated. To address this violation and due to the smaller sample size, I utilized an alpha value of ≤ .10 for reliability as an acceptable standard to declare a statistically significant relationship between variables (Teigen & Jøgensen, 2005).

Table 3

Calculated Frequency Values of Participants' Responses

Variable level and score range	*N*	Percent*
Perceived self-efficacy (DV)		
High level (80-90)	25	38
Moderate level (41-79)	40	59
Low level (0-40)	3	4
Military cultural competence (IV)		
High level (5-6)	28	41
Moderate level (4)	13	19
Low level (1-3)	27	40
Socialization tactics (IV/moderator)		
Institutionalized socialization tactics (5-7)	32	47
Combination of individualized and institutionalized socialization tactics (4)	18	26
Individualized socialization (1-3)	18	26

Note: $n = 68$. *Percentages were rounded.

The frequency values of participants indicated the majority of the participants' responses were in the range of having higher levels of military cultural competence ($n = 28$), closely followed by 27 respondents whose responses fell within the range of lower levels (shown in Table 3). For socialization tactics, the majority of the participants' responses fell within the range to indicate institutionalized socialization tactics were used by staff in their organization during onboarding ($n = 32$). The majority of the values of participants' responses to statements related to levels of perceived self-efficacy fell within the "moderately can do" range ($n = 40$).

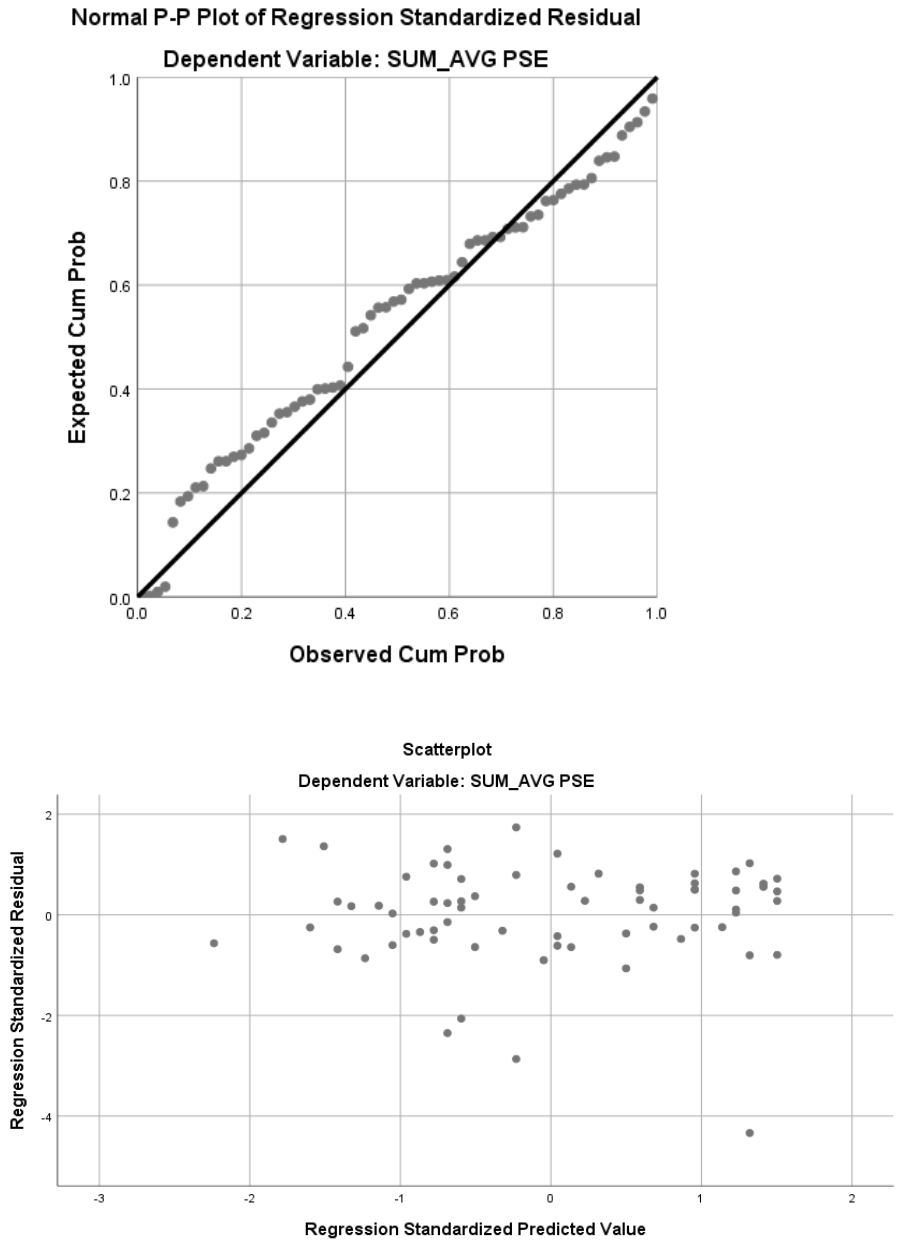

Figure 2. Normal probability plot (P-P) and scatterplot.

The assumptions of normality, linearity, and homoscedasticity for standard multiple regression were further examined by reviewing the normal probability plot (P-P) (Figure 2 left) and scatterplot (Figure 2 right) of the regression standardized predicted

value and standard residual for levels of perceived self-efficacy as the dependent variable. Both graphs demonstrated slight deviations from normality, with assumption of normality met. When reviewing normal P-P, the assumption of normality was met; however, when reviewing the scatterplot (Figure 2 right) of the standardized residuals, I found the normalized predicted values showed two instances of outliers but no strong deviation from the rectangular pattern. I would consider the assumption of homoscedasticity was met with a slight deviation. Levels of military cultural competence and socialization tactics were the independent variables in this study while the dependent variable represented the levels of perceived self-efficacy. To summarize, after examining the data contained in the graphs, preliminary analysis showed there were no major violations in the assumptions of normality and homoscedasticity.

Table 4

Correlation Matrix for Perceived Self-Efficacy, Military Cultural Competence, and Socialization Tactics

Variable	M	SD	1	2	3
1. PSE	4.17	1.22	-		
2. MCC	4.30	.99	.861		
3. SOCTACT	69.76	18.20	.296	.367	-

Multicollinearity exists when more than two predictors variables have a strong correlation (Diebold, 2013; McKinnon, 2011). After reviewing the results of Pearson's correlation (Table 4) between independent variables military cultural competence and

socialization tactics, I found the correlation within an acceptable range (r = .367, p = .002). A large correlation was found between independent variable, military cultural competence, and dependent variable, perceived self-efficacy (r = .861, p < .001). There was also a small correlation and statistically significant relationship found between independent variable, socialization tactics, and dependent variable, perceived self-efficacy (r = .296, p = .014). I also assessed the tolerance parameters and found the values (Tolerance = .865, VIF = 1.155) were within the acceptable limits of Tolerance > .10 and VIF < 10 for all variables (Bager, Roman, Algelidh, & Mohammed, 2017). With these values, I determined the assumptions of multicollinearity were not violated and were met for the correlation between the independent variables, levels of military cultural competence and socialization tactics.

Hypothesis Testing

Nedegaard and Zwilling's (2017) MCCP assessment subscale which contained nine items, under the section of Knowledge and Awareness, were used to measure levels of military cultural competence relating to the military and conditions affecting veterans and their family members. Responses were collected based on a 6-point Likert-scale (1 = Strongly disagree to 6 = Strongly agree), with lower scores (1-3) indicating lower levels of military cultural competence, neutral score (4) indicated neither lower or higher levels, and higher scores indicating higher levels (5-6) (found at Table 3). Cronbach's alpha, presented by Nedegaard and Zwilling (2017), identified α = 0.958 for the Knowledge and Awareness section. I tested Cronbach's alpha, which confirmed reliability and an

adequate level of internal consistency (α = 0.968). All responses to subscale items were summed and averaged for final analysis.

The 17 items in the Confidences in Abilities/Abilities section of the MCCP (Nedegaard & Zwilling, 2017) was used to examine the reported levels of perceived self-efficacy. Self-efficacy is considered task-oriented and defined as the ability to complete difficult tasks or achieve goals with positive outcomes (Bandura, 1993). Subscale items were measured by selecting a response on a scale of 0 – 100. Scores were summed and averaged to establish the levels of self-efficacy, with lower scores (0 – 40) representing lower levels (cannot do at all), moderate scores (41 – 79) for moderate levels (moderately can do), and higher scores (80 – 100) representing high levels (highly certain can do). Nedegaard & Zwilling (2017) reported a high Cronbach's alpha of the Confidences in Abilities/Abilities section 0.943. Reliability and an adequate level of internal consistency were confirmed (α = 0.962). All responses to subscale items were used for the survey and scores were summed and averaged for final analysis.

I examined the correlation and statistically significant relationship between the levels of military cultural competence and levels of self-efficacy. A review of the histogram and probability plot (P-P) of the residuals (Figure 3) with levels of perceived self-efficacy as the dependent variable and levels of military cultural competence as the independent variable, I determined there was a slight deviation from normality. Based on the results, I am suggesting that levels of military cultural competence are positively correlated with levels of perceived self-efficacy (r = .861) and there is a statistically significant relationship, $p < .001$ (Table 4). The null hypothesis was rejected because a

statistically significant relationship was found between levels of military cultural competence on levels of perceived self-efficacy.

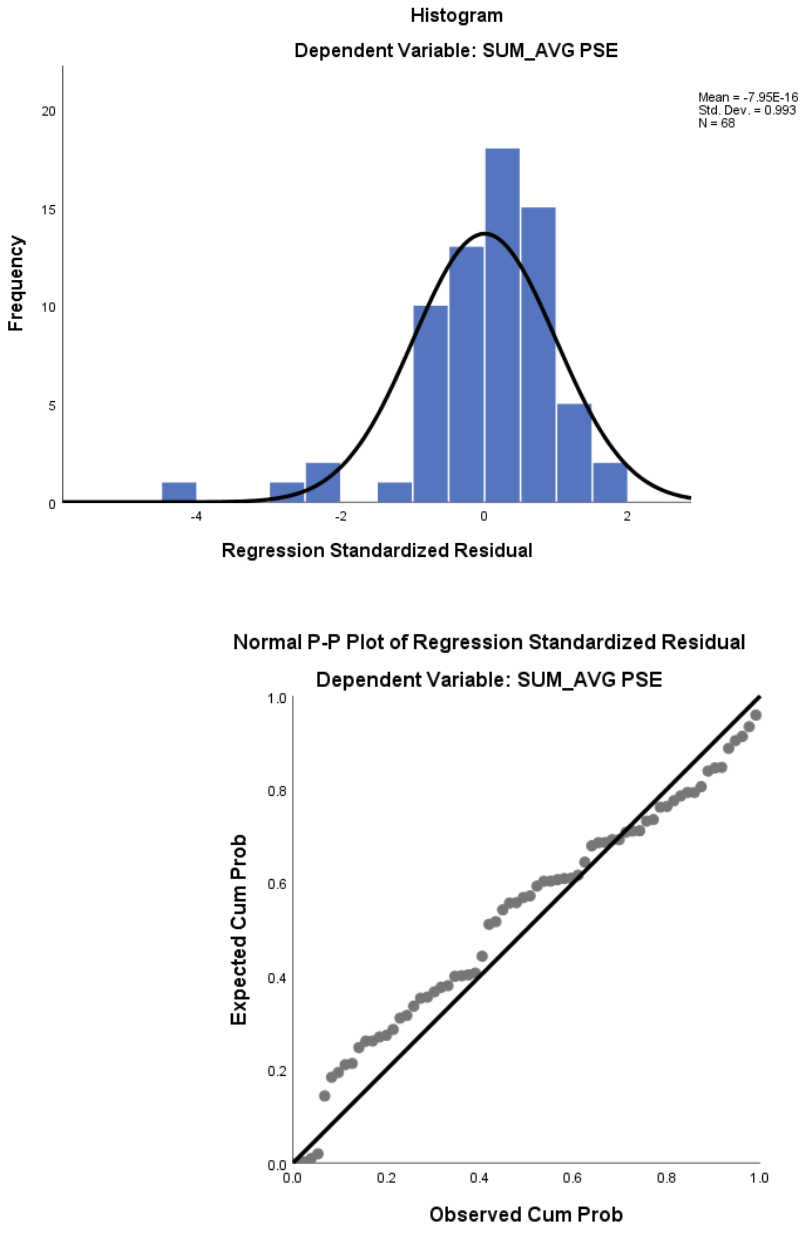

Figure 3. Histogram and normal probability plot (P-P).

The Socialization Tactics assessment scale (Jones, 1986), which contained six domains with 5-item scales, was used to evaluate whether individualized or institutionalized socialization tactics were employed by the COC Program member organizations. The items on this scale were scored on a 7-point Likert-type scale (1 = Strongly disagree to 7 = strongly agree). Lower scores (1-3) indicated individualized socialization tactics, with high scores (507) indicating institutionalized (found in Table 3). Reliability of the domains of the instrument was reported in the range of 0.68 to .084 (Jones, 1986); however, collapsing the dimensions into one factor for analysis yielded reliability of alpha 0.84 (Gruman et al., 2006). This study utilized the methodology followed by Gruman et al. (2006) of collapsing the domains into one factor for analysis, which yielded a Cronbach's alpha to confirm reliability and adequate level of internal consistency (α = 0.967). All responses to subscale items were transformed, then summed and averaged for final analysis.

In addition to the Socialization Tactics scale (Jones, 1986), levels of self-efficacy were examined utilizing the 17 questions of Confidence in Abilities/Abilities subscale (Nedegaard & Zwilling, 2017). When examining the relationship between socialization tactics and levels of perceived self-efficacy, I found a small positive correlation between the variables (r = .296) and a statistically significant relationship (p = .014) (Table 4). The null hypothesis was rejected because a statistically significant relationship was found between socialization tactics and levels of perceived self-efficacy. I reviewed the histogram and normal probability plot (P-P) of the residuals with levels of perceived self-

efficacy as the dependent variable and socialization tactics as the independent variable and neither graph demonstrated deviations from normality (Figure 4).

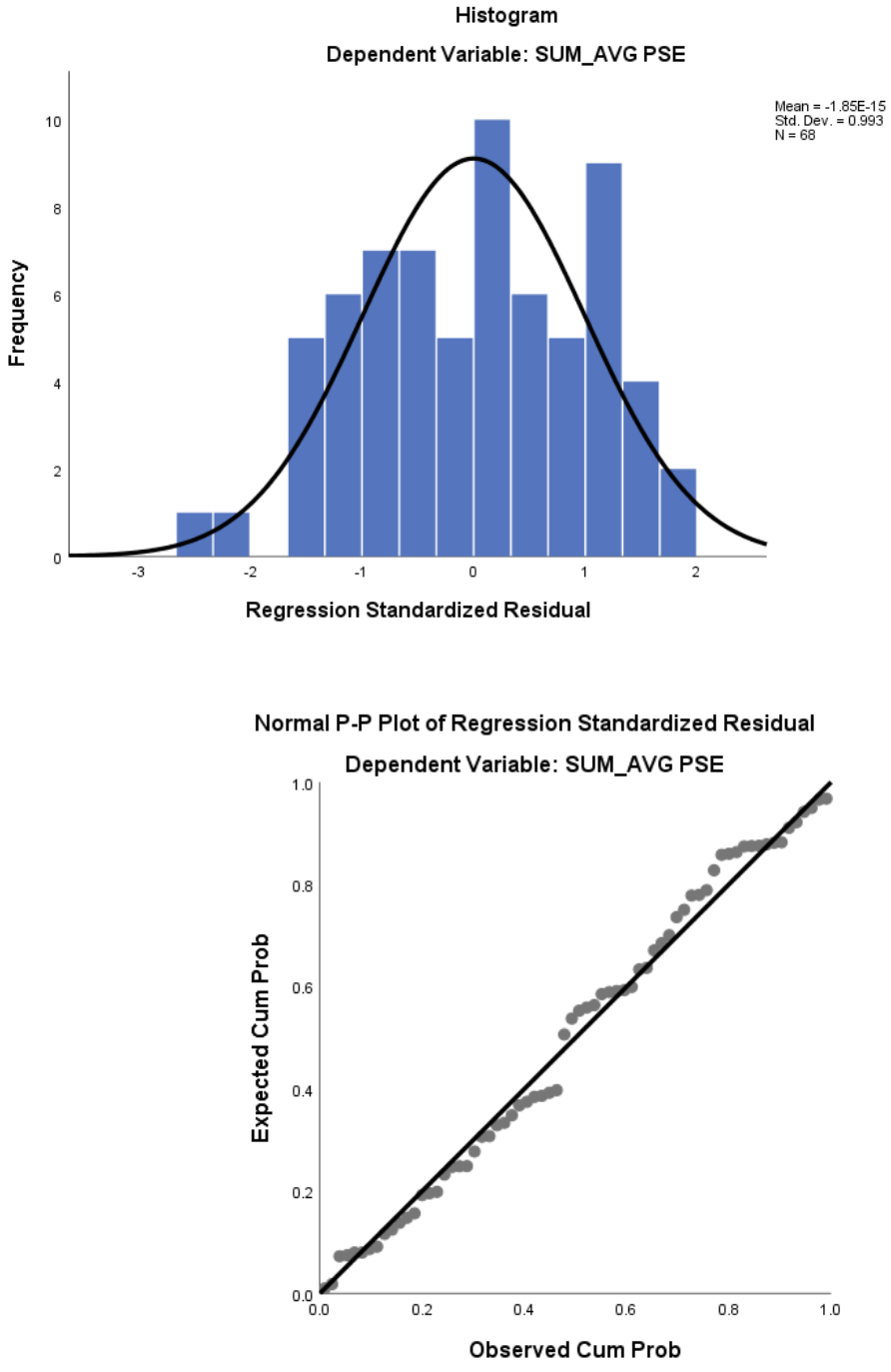

Figure 4. Histogram and normal probability plot (P-P).

The third research question examined the relationship between the independent variables, socialization tactics and levels of military cultural competence. A small correlation was found (r = .367) when conducting a bivariate analysis which depicted statistical significance relationship between military cultural competence and socialization tactics (p = .002) (Table 4). The null hypothesis was rejected because a statistically significant relationship was found between levels of military cultural competence and socialization tactics.

Moderation Analysis

Moderation explains "when" or under what condition a dependent variable and independent variable are related (Hayes & Rockwood, 2017). As an example, for this study, the hypothesis tested whether levels of perceived self-efficacy are or are not related to levels of military cultural competence and socialization tactics. Also, the tests included whether socialization tactics moderated that relationship, and if so, whether at lower or higher levels of military cultural competence and perceived self-efficacy. According to Baron and Kenny (1986), to conduct a moderation analysis, X (military cultural competence) is presumed to be related to Y (perceived self-efficacy); which a statistically significant relationhip has been found in this study. Second, X and M (socialization tactics) were centered to avoid multicollinearity by subtracting the mean, as described by Diebold (2013). Then X and centered-M were multiplied to create an interaction term. Regression was run to determine if M has an effect between X and Y and if the effect between X and Y goes to zero, with the addition of M (McKinnon,

2011). A simple moderation analysis graphic that depicts this possible relationship is provided in Figure 5.

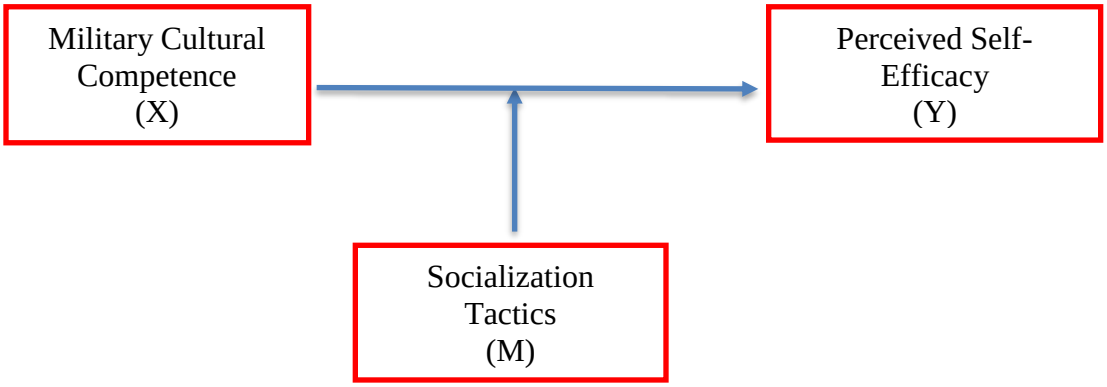

Figure 5. Simple Moderation Analysis.

Results of Moderation Analysis

The hypotheses were tested to determine whether the relationship between the levels of military cultural competence on levels of perceived self-efficacy was moderated by socialization tactics. Predictor variables (levels of military cultural competence and socialization tactics) were centered by subtracting the mean (Diebold, 2013). An interaction term was created from the product of the centered moderator variable and predictor variable (Baron & Kenny, 1986; Diebold, 2013; McKinnon, 2011.

The first two steps involved the assumption of whether there is a statistically significant relationship between each of the independent variables and the dependent variable, with the third step to test the relationship between the two independent variables. Subsequent tests assessed the relationships and effect of the centered variables, and the interaction term. Table 5 introduces the values associated with the centered variables, military cultural competence (ZMCC) and socialization tactics (ZSOCTACT),

and the interaction term (MCC*ZSOCTACT). There is no change in variance between the original variables and centered variables.

Table 5

Predicted and Residual Values of Moderated Interaction

	Minimum	Maximum	Mean	Standard deviation
Predicted value	34.77	94.40	69.76	15.690
Residual	-39.624	15.708	.000	9.217
Std. predicted value	-2.230	1.571	.000	1.000
Std. residual	-4.202	1.666	.000	.977

Table 6

ANOVA Results for the Interaction Between Socialization Tactics and Levels of Military Cultural Competence on Levels of Perceived Self-Efficacy

	Sum of squares	*Df*	Mean square	*F*	Sig.
Regression	16493.479	3	5497.826	61.815	.000
Residual	5692.151	64	88.940		
Total	22185.630	67			

Table 7

Moderated Regression Analysis with Centered Military Cultural Competence as IV, Socialization Tactics as Moderator, and Perceived Self-Efficacy as Outcome Variable

	Unstandardized coefficients		Standardized coefficients			90% CI		Partial correl
	B	SE	Beta	*t*	Sig.	LL	UL	
(Constant)	3.201	19.471		.164	.870	-29.296	35.698	
ZMCC	16.034	4.771	1.073	3.361	.001	8.071	23.997	.387
ZSOCTACT	-.404	1.249	-.022	-.324	.747	-2.488	1.680	-.040
MCC*SOCTACT	-.701	1.074	-2.08	-.652	.517	-2.494	1.093	-.081

The overall moderation analysis regression model was found to be significant, $F(3,64) = 61.815$, $p < .001$ (Table 6). In this model, socialization tactics were not a predictor of levels of perceived self-efficacy, $b = -.404$, $p = .747$ (Table 7). Similarly, the interaction term, military cultural competence and centered-socialization tactics, did not produce a statistically significant effect, $b = -.701$, $p = .517$ (Table 7). Based on these results, the null hypothesis is accepted, indicating there is no statistically significant relationship between levels of military cultural competence on levels of perceived self-efficacy when socialization tactics are used by CoC Program member organizations when onboarding nonmedical nonclinical service providers who serve veterans experiencing homelessness. No further analysis was conducted.

Summary

I tested each hypothesis for the first three research questions utilizing bivariate correlation analysis. Levels of military cultural competence were found to have a statistically significant positive relationship with levels of perceived self-efficacy, rejecting the null hypothesis, which corroborated Nedegaard and Zwilling's (2017) finding. The null hypothesis was also rejected in the second research question when examining the relationship between socialization tactics and levels of perceived self-efficacy, which corroborated Jones' (1986) finding. Results of the third research question indicated there was a statistically significant relationship between the two independent variables, military cultural competence and socialization tactics, which were found to be correlated and statistically significant.

Moderation analysis was used to examine the moderating effect of socialization tactics on the relationship between the levels of military cultural competence on levels of perceived self-efficacy. The overall regression model was found to be significant; however, socialization tactics was not found to moderate that relationship. The interaction term, which was the product of the values of military cultural competence and socialization tactics, was not statistically significant. Based on the findings, there was significant evidence to accept the null hypothesis and conclude that socialization tactics did not moderate the relationship between levels of military cultural competence on levels of perceived self-efficacy. Further interpretation of these key findings, limitations of the study, as well as recommendations and implications are presented in Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this quantitative cross-sectional study was to examine whether there is a statistically significant relationship between levels of military cultural competence, socialization tactics, and levels of perceived self-efficacy. The study also examined whether socialization tactics moderated the relationship between levels of military cultural competence on levels of perceived self-efficacy. First, I examined the correlation and relationship between levels of military cultural competence and levels of perceived self-efficacy. Findings revealed a high correlation between the two variables and a statistically significant relationship. Second, I examined the correlation and relationship between socialization tactics and levels of perceived self-efficacy. Findings revealed a small correlation and a statistically significant relationship. Next, I examined whether the two independent variables were correlated and if there was a statistically significant relationship. Findings also revealed a small correlation and statistically significant relationship.

These findings led to the last statistical test, where I examined whether socialization tactics moderated the relationship between levels of military cultural competence on levels of perceived self-efficacy. I used multiple linear regression to test the effect of the independent variables, centered variables, and interaction term on the dependent variable. The results of the tests indicated there was not a statistically significant relationship; therefore, I deduced socialization tactics did not moderate the

relationship between levels of military cultural competence on levels of perceived self-efficacy.

The research goals were achieved to add to the body of literature that confirmed the relationship between levels of military cultural competence and levels of perceived self-efficacy, as well as between socialization tactics and levels of self-efficacy. Also, I examined the added dimension of whether socialization tactics moderated the relationship between levels of military cultural competence on levels of perceived self-efficacy. The findings of this study suggest a corroboration of a previous study conducted by Nedegaard and Zwilling (2017) that found a statistically significant relationship between levels of military cultural competence and levels of perceived self-efficacy, a study by Gruman et al. (2006) that found a statistically significant relationship between socialization tactics and levels of perceived self-efficacy. However, I found no literature from researchers who examined the relationship between the levels of military cultural competence, socialization tactics, and levels of perceived self-efficacy for comparison.

Numerous studies focused on military cultural competence when assessing impact of interaction between service providers and clients and outcomes of clients in the medical or clinical settings (Koenig et al., 2014; Tanielian et al., 2016). In contrast, this study offered the perspective of self-report data collected from nonmedical nonclinical service providers. Articles by researchers such as Canfield and Weiss (2015), Coll et al. (2011), Nedegaard and Zwilling (2017), and Meyer et al. (2016) considered military cultural competence based on training, which was not the focus of this study. Also, the previous studies did not address socialization tactics of an organization as an influencing

factor for veterans, though research has supported socialization tactics as a predictor of levels of self-efficacy for other populations.

Interpretation of the Findings

Theoretical Foundation

I found that self-efficacy as the theoretical foundation supports the findings of this study where participants who reported higher levels of perceived self-efficacy in supporting veterans also reported having higher levels of military cultural competence. The findings of the study are similar to Bandura's (1993) self-efficacy theory when individuals who reported higher levels of self-efficacy believed they could complete a task or reach their goals with accuracy and that they possessed the competence to do so. Conversely, I found that the results suggested service providers reporting lower levels of military cultural competence did not specifically report lower levels of perceived self-efficacy when supporting this population. Nedegaard and Zwilling (2017) found individuals who reported higher levels of military cultural competence also reported having higher levels of self-efficacy in completing the task of supporting veterans. In this study, the majority of the nonmedical nonclinical service providers self-reported as having higher levels of military cultural competence and considered themselves possessing both the knowledge, confidence, and abilities to perform tasks to support veterans.

Self-efficacy was the foundational theory when Jones (1986) examined the relationship between socialization tactics and the effects of self-efficacy on role orientation of employees and found a statistically significant relationship. Jones (1986)

posited individuals with higher levels of self-efficacy may not be impacted by socialization tactics regardless of whether individualized or institutionalized; however, socialization tactics have a greater effect when individuals have lower levels of self-efficacy. Self-efficacy was supported as the foundational theory for this study.

Levels of Military Cultural Competence and Levels of Perceived Self-Efficacy

After reviewing the results of the first research hypothesis, I found a statistically significant relationship between levels of military cultural competence, independent variable, and levels of perceived self-efficacy, dependent variable. There was a large positive correlational relationship suggesting the constructs of the independent and dependent variables are similar. The positive association and statistically significant relationship found in this study confirmed Nedegaard and Zwilling's (2017) findings that suggested service providers believed their reported levels of military cultural competence affected their perception of whether they could carry out the tasks associated with supporting veterans experiencing homelessness.

In the context of this study, service providers supporting veterans experiencing homelessness may report higher levels of perceived self-efficacy when they see themselves possessing higher levels of military cultural competence. As an example, possessing knowledge, confidence, and abilities in the military-related topics or conditions affecting veterans through military service, exposure, or training may assist a service provider in feeling comfortable or confident attempting or completing tasks supporting veterans. In this study, participants who reported lower levels of military

cultural competence was not congruent with the number of participants reporting lower levels of perceived self-efficacy.

Socialization Tactics and Levels of Self-Efficacy

Results of the hypothesis that tested the second research question are interpreted to indicate socialization tactics have a positive effect and a statistically significant relationship with levels of perceived self-efficacy. The small correlation suggests the constructs are similar but not enough to be concerned about multicollinearity. Wang, Hom, and Allen (2017) found that the right mix of socialization tactics may increase job satisfaction and decrease intentions to quit after 3 months of employment. The researchers argued that monitoring of employees' attitudes early after onboarding would offer a glimpse into their views of realistic expectations of associated tasks (Wang et al., 2017). Based on the findings of this study, socialization tactics may influence how service providers perceive their ability to attempt or complete tasks associated with supporting veterans experiencing homelessness. There were an equal number of participants whose responses neither identified more individualized than institutionalized socialization tactics compared to individualized, which suggests the need for feedback from new employees to identify the right mix, as suggested by Wang et al. (2017).

Levels of Military Cultural Competence and Socialization Tactics

When testing the third hypothesis, I found the two independent variables were correlated and had a statistically significant relationship with a small positive correlation (r = .296). I found no studies to date that have examined the relationship between levels of military cultural competence and socialization tactics; therefore, there were no results

for comparison or contrast. I added a dimension to the literature by introducing the relationship between these independent variables for consideration when addressing effects of service provider interaction and engagement with veterans. The statistically significant relationship between the two predictor variables suggests further research is needed to examine how organizations are including effects of socialization tactics to increase military cultural competence when onboarding or acclimating service providers to better prepare their staff to serve the veteran population.

Meyer et al. (2015), Tanielian et al. (2016), and Ulberg et al. (2016) examined military cultural competence in the healthcare or mental health settings and found evidence that confirmed impact to both outputs and outcomes. The literature did not focus on whether socialization tactics or organizational factors influenced the delivery of service. The results of this study did not identify whether military cultural competence affects the outputs of service providers or outcomes of clients served.

Moderation of Socialization Tactics on the Relationship Between Levels of Military Cultural Competence on Levels of Perceived Self-Efficacy

I used multiple regression analysis to examine whether socialization tactics affected the relationship between levels of military cultural competence on levels of perceived self-efficacy. The results of the regression of the centered independent variables, the interaction term, and dependent variable were not significant. Together, socialization tactics, military cultural competence, and the interaction between the two accounted for 86% of the variance; however, there was a negative association with no statistically significant relationship between moderator (p = .747), interaction term (p =

.517), and the dependent variable. Although this study was the first to evaluate whether socialization tactics moderated the relationship between levels of military cultural competence on levels of perceived self-efficacy, other studies have shown the statistically significant relationships between socialization tactics and levels of military cultural competence as separate and distinct independent variables and predictors of levels of perceived self-efficacy (Ashforth & Saks, 1996; Gruman et al., 2006; Jones, 1986; Meyer et al., 2015; Nedegaard & Zwilling, 2017). Further research is required to determine whether prior service or exposure, age, gender, length of employment, or the type of member organization influenced the lack of statistically significant findings.

Limitations of the Study

Limitations exist with this study, such as the cross-sectional design, self-report of data, and use of a third-party disseminating recruitment material. I was able to receive enough participants to meet a sample to achieve an 80% effect, but only after the data collection period had to be extended due to extreme weather conditions. As discussed in Chapter 1, there are limitations with the ability to generalize the findings of the study and validity of the conclusions based on a small sample size. Service providers are only represented who may share the same characteristics as those who took part in the study and not indicative of the entire target population.

Participants were asked to self-affirm meeting the delimitation criteria with no option for verification of information before participation. The survey did not solicit a response to establish the length of time employed (e.g., no less than four months and no more than 18 months). Also, participants were asked to complete the survey by recalling

information related to their military cultural competence, socialization tactics used by the organization, and perceptions of self-efficacy related to tasks performed supporting veterans experiencing homelessness.

Another limitation was the use of CoC Program member organization staff to disseminate recruitment materials. This method to recruit participants offered confidentiality of the potential participants but preventing the researcher from having direct access or contacting participants to clarify study purpose or instructions. Participants indirectly received the recruitment materials via e-mail, hardcopy, or other sources; therefore, the actual method is not known.

There was an estimated 49% of the participants who reported they served in the military or the spouse of someone who served; which may be considered an over representation of military-affiliated participants. The over representation of this type of participant was also identified as a limitation in a prior study conducted by Nedegaard and Zwilling (2017). Similarly, many of the participants reported their professional affiliation as volunteer coordination/volunteer, which may also be considered over representation of that category. This finding is not abnormal because CoC Program member organizations consisting of federal, state, local, nonprofit and religious organizations that traditionally utilize volunteers to support their mission. It is not known whether the experience of volunteers who report socialization tactics when onboarding would be the same for paid employees. Jones (1986) argued organizations who use different socialization tactics that meet the needs of newcomers contributes to different

outcomes, while Gruman et al. (2006) posited socialization tactics influence how newcomers respond to their organization.

The high level of correlation between the independent variable, levels of military cultural competence and dependent variable, levels of perceived self-efficacy was another limitation in this study. This was not considered multicollinearity because the high correlation was between an independent and dependent variable. I paid attention to the correlations due to the stated concerns of convergent or discriminant validity of the instrument (see Nedegaard & Zwilling, 2017) or the possibility of the presence of multicollinearity of the variables affecting the ability to accurately interpret the findings due to over or under stated effects (see Ray-Murkherjee et al., 2014).

Recommendations

I examined the relationship between levels of military cultural competence, socialization tactics, and levels of perceived self-efficacy with a quantitative study. A qualitative study of the experiences of newcomers through focus groups or by conducting interviews may yield a better understanding of the triadic relationship between military cultural competence, socialization tactics, and service provider's perceived self-efficacy. Survey questions did not include the participants' perspective of ability to build rapport, whether the contact was direct, or whether they considered their level of military cultural competence, socialization tactics, or level of perceived self-efficacy had an impact on their engagement and interaction with veterans. The study findings are also limited in discerning whether service providers considered lower levels of military cultural competence, socialization tactics employed by the organization, or lower levels of self-

efficacy a barrier to access or use of programs and services as they performed tasks based on their employer/volunteer organization's mission and goals.

I did not consider other predictors, such as age, gender, or prior military service as possible influences or effect. Also, race was not collected as a demographic characteristic or considered as a variable. Adding race and comparing exposure, prior service, or training that possibly influenced self-report of levels of military cultural competence. Inclusion of additional variables may better inform findings by addressing predictors associated with levels of perceived self-efficacy when attempting tasks that support veterans experiencing homelessness. Although other predictors were not included in this study, I followed the purpose of the study to examine the relationship between military cultural competence, socialization tactics, and perceived self-efficacy of service providers employed with CoC member organizations, who served veterans experiencing homelessness.

I also suggest a mixed-methods study to offer more insight of the lived experience of nonmedical nonclinical service providers. A mixed method study would provide the perspective and specificity of whether military cultural competence training or socialization tactics shaped the service providers' experience. This specificity may be achieved by further examination to collect data that better informs the affiliation of volunteer or paid staff of CoC Program member organizations. Also, other categories of affiliation reported, such as outreach, intake, admin, executive director, and food bank worker may report different experiences than the majority of the participants in this study while engaging with veterans or performing their respective tasks.

CoC Program member organizations consist of federal, local, state, nonprofit, and religious organization, all of which could solicit, train, and utilize volunteers. The type of member organization was not considered as a predictor when conducting this study, though it would have led to a better understanding of the larger number of participants affiliated with volunteer coordinator/volunteer roles. Also, service providers may have worked with other member organizations supporting this population before data collection for this study, which could influence their levels of military cultural competence or levels of perceived self-efficacy.

This study focused on newcomer's report of experiences and level of military cultural competence and perceived self-efficacy but does not examine the performance of tasks from the lens of a supervisor or in respect to the organizational mission. Another perspective to consider is that of veterans which may provide insight into the ability to establish rapport or feel supported when engaging with nonmedical nonclinical service providers. There is limited literature that has considered nonmedical nonclinical service providers working with veterans, except for Nedegaard & Zwilling (2017); however, that study also included the examination of responses from medical and clinical staff.

Adverse treatment of veterans and nonveterans experiencing homelessness (Miller & Keys, 2001) has been reported as a barrier to access and use of programs and services (Cretzmeyer et al., 2014). Self-report of service providers indicated a lack of military cultural competence as a factor that impacts building rapport and affecting their engagement with veterans (Matarazzo et al., 2015). Additionally, the training and

acclimation programs and processes have been found to have an effect on role identity and newcomer orientation (Perrot et al., 2014).

Community stakeholders who support veterans experiencing homelessness may find this study useful when considering socialization tactics and training efforts when onboarding new employees. Military cultural competence was found to be an essential factor in establishing rapport and improving outcomes in medical and clinical settings (Meyer, 2013; Tanielian et al., 2016). Researchers were instrumental in establishing the need for training on military culture for organizations and service providers supporting veterans (Nedegaard & Zwilling, 2017; Tanielian et al., 2016).

Training on military culture has been added to the curriculum of academic programs as part of the pedagogy for civilian service providers serving in military organizations or veterans' health establishments, such as the Veterans Health Administration (Meyer, 2013). This study did not examine training that increases levels of military cultural competence, as part of an onboarding process, or whether training increased levels of perceived self-efficacy. Examining specific evidence-based training that has been proven to provide service providers with the confidence in completing tasks associated with performing their duties of serving veterans experiencing homelessness is recommended for future studies. It may also be beneficial to examine the military cultural competence level of new employees charged with serving the veteran population to assess the proper training modality or acculturation methodology to meet the organization's mission.

It is recommended that caution be taken when interpreting these results, due to the high correlational values of the independent variable, levels of military cultural competence, and dependent variable, levels of perceived self-efficacy. The researchers, Nedegaard & Zwilling (2017) offered the same caution due to the instrument, Military Cultural Competence Program assessment scale lacking convergent and discriminant validity. Based on the high correlation and threat of multicollinearity, I utilized Diebold's (2013) guidance to center the predictor variables and create an interaction term to add to the regression. I recommend additional statistical tests to examine the relationship of the constructs and address multicollinearity. As an example, Bager et al. (2017) recommended the ridge regression application to address multicollinearity.

Implications

I embarked on this study to add to the body of literature to address the problem of adverse treatment by service providers which leads to barriers to access and use of programs and services for veterans experiencing homelessness. Results of this study that examined levels of self-efficacy as an outcome influenced by levels of military cultural competence and socialization tactics would offer leadership with options for onboarding, training, and staff development. Jones (1986) argued different tactics support different outcomes, which was supported by Batistič (2018), who argued newcomers benefit from different socialization tactics and strategies and should be based on the type of organization and its mission.

Findings of this study suggest socialization tactics did not have an effect or influence perceived self-efficacy of service providers supporting veterans experiencing

homelessness when controlling for military cultural competence. However, in spite of the limitations noted, a conscientious human resources office staff or the organization's leadership may want to consider how to best tap into the newcomer's potential by and decrease turnover if employees don't believe they have the necessary information or skills to support this population. This study also added the dimension of examining the relationship between military cultural competence and socialization tactics, which found a positive correlation and a statistically significant relationship. Community stakeholders who have an investment in programs and services that support veterans experiencing homelessness may find this study useful when considering socialization tactics and training efforts when onboarding new employees.

Conclusion

The new employee experience is shaped by feedback given and help-seeking behaviors identified (Perrot et al., 2014; Saks & Gruman, 2018). Just as military cultural competence has been found to affect self-efficacious thinking and behavior when dealing with veterans, prior research supports socialization tactics influencing how newcomers acclimate and perform associated tasks. Combining these two predictors in this study did not suggest a significant effect on how service providers perceive how well they serve veterans. However, the findings of this study, provides organization leadership with additional information when considering whether to employ either formal (institutionalized), informal (individualized), or a combined approach as a strategy for socialization tactics. Consideration given to strategy for onboarding and acclimation of newcomers, in performing the tasks associated with the role of nonmedical nonclinical

service providers, may have an effect on how service providers view their ability to interact or assist veterans. This along with an increased understanding of the relationship between levels of military cultural competence and levels of self-efficacy has the potential to offer a more comprehensive approach to preparing employees to perform their duties of supporting veterans.

This study examined whether levels of self-efficacy was influenced by levels of military cultural competence and whether socialization tactics moderated that relationship. Adding the dimension of socialization tactics when examining levels of military cultural competence is the first of its kind that I am aware of. Though the statistical tests did not yield a statistically significant relationship for moderation when adding socialization tactics, the correlation and statistically significant relationship between military cultural competence and socialization tactics should not be ignored.

This study suggests that organizational leadership and human resource professionals should pay attention to the needs of service providers when establishing policies and procedures related to socialization tactics. Adverse treatment is never a goal of organization staff but a lack of knowledge, confidence, and ability may inadvertently lead to creating barriers to access and use of the programs and services intended to support the target population, in this case, veterans experiencing homelessness. Utilizing the information from this study, in whole or part, organizational leaders have the unique opportunity to make decisions about onboarding, training, and retention based on the needs of the employee, which may also increase the capacity and functioning of the organization.

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Appendix A: Permission to Reproduce the Military Culture Certificate Program Scale

8/21/2019 [redacted]

Re: Permission to Reprint Scale in Dissertation Document

Nedegaard, Randy [redacted]

Thu 8/22/2019 12:40 AM

To: Dorothy Seabrook [redacted]

Yes, absolutely. Go ahead and reprint the scale in your dissertation.

Congratulations!

If you need to contact me further, I have moved. My new email is: [redacted]

Take care,

Randy

Randy Nedegaard, Ph.D.
Associate Professor
[redacted]

From: Dorothy Seabrook <[redacted]>
Date: Tuesday, August 20, 2019 at 12:56 PM
To: Me [redacted]
Subject: Permission to Reprint Scale in Dissertation Document

Good Day Dr. Nedegaard,

You previously provided permission for me to use the Military Cultural Certificate Program scale in my dissertation study. I am also required to obtain permission to reprint the scale in my published dissertation. Please accept this email as request for permission to do so. Thanks in advance.

v/r
Dorothy A. Seabrook, MEd, HS-BCP
Walden University
[redacted]

Appendix B: Military Cultural Competence Scale

Military Culture Certificate Program – Copy

What is your professional affiliation?

- ❍ Social Worker
- ❍ Psychologist
- ❍ Licensed Counselor
- ❍ Licensed Addictions Counselor
- ❍ Other mental health professional
- ❍ Human Service Worker
- ❍ Lawyer
- ❍ Pastor
- ❍ Nurse
- ❍ Physician (or medical student)
- ❍ Physical therapist/Occupational Therapist
- ❍ Other health care provider
- ❍ Emergency worker
- ❍ Law Enforcement
- ❍ Teacher/education
- ❍ Neighbor/friend of a veteran
- ❍ Other - please specify _____

Have you ever or do you now work directly with Veterans and/or their family members?

- ❍ Yes
- ❍ No

To what extent do you or have you worked with veterans and their families?

- ❍ Extensively
- ❍ Often
- ❍ Occasionally
- ❍ Rarely
- ❍ Never

Please comment on how you have worked with veterans or their family members:

What is your age?

- ❍ Under 25
- ❍ 25-35
- ❍ 35-45
- ❍ 45-55
- ❍ 55-65
- ❍ 65-75

What is your gender?

- ❍ Female
- ❍ Male
- ❍ Other/No reply

Please indicate your level of agreement to the following statements by clicking on the appropriate number that corresponds with the key below:

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
I am well versed in the language and acronyms commonly used in the military	❍	❍	❍	❍	❍	❍
I fully understand the rank and organizational structure of the military	❍	❍	❍	❍	❍	❍
I can fully appreciate what it is like to be deployed or have a family member deployed	❍	❍	❍	❍	❍	❍
I am completely aware of the impact military life has on family members	❍	❍	❍	❍	❍	❍
I am well aware of the behavioral health issues commonly found in the military	❍	❍	❍	❍	❍	❍

I understand the unique ethical issues associated with military service	❍	❍	❍	❍	❍	❍
I am very knowledgeable about the many services that are available to veterans and their families	❍	❍	❍	❍	❍	❍
I feel well educated about the political issues and the important historical aspects of recent conflicts	❍	❍	❍	❍	❍	❍
Overall, I feel a strong sense of connection to the military and its members	❍	❍	❍	❍	❍	❍
I am well versed in the language and acronyms commonly used in the military	❍	❍	❍	❍	❍	❍

I am well versed in the language and acronyms commonly used in the military	❍	❍	❍	❍	❍	❍
I fully understand the rank and organizational structure of the military	❍	❍	❍	❍	❍	❍
I can fully appreciate what it is like to be deployed or have a family member deployed	❍	❍	❍	❍	❍	❍
I am completely aware of the impact military life has on family members	❍	❍	❍	❍	❍	❍
I am well aware of the behavioral health issues commonly found in the military	❍	❍	❍	❍	❍	❍

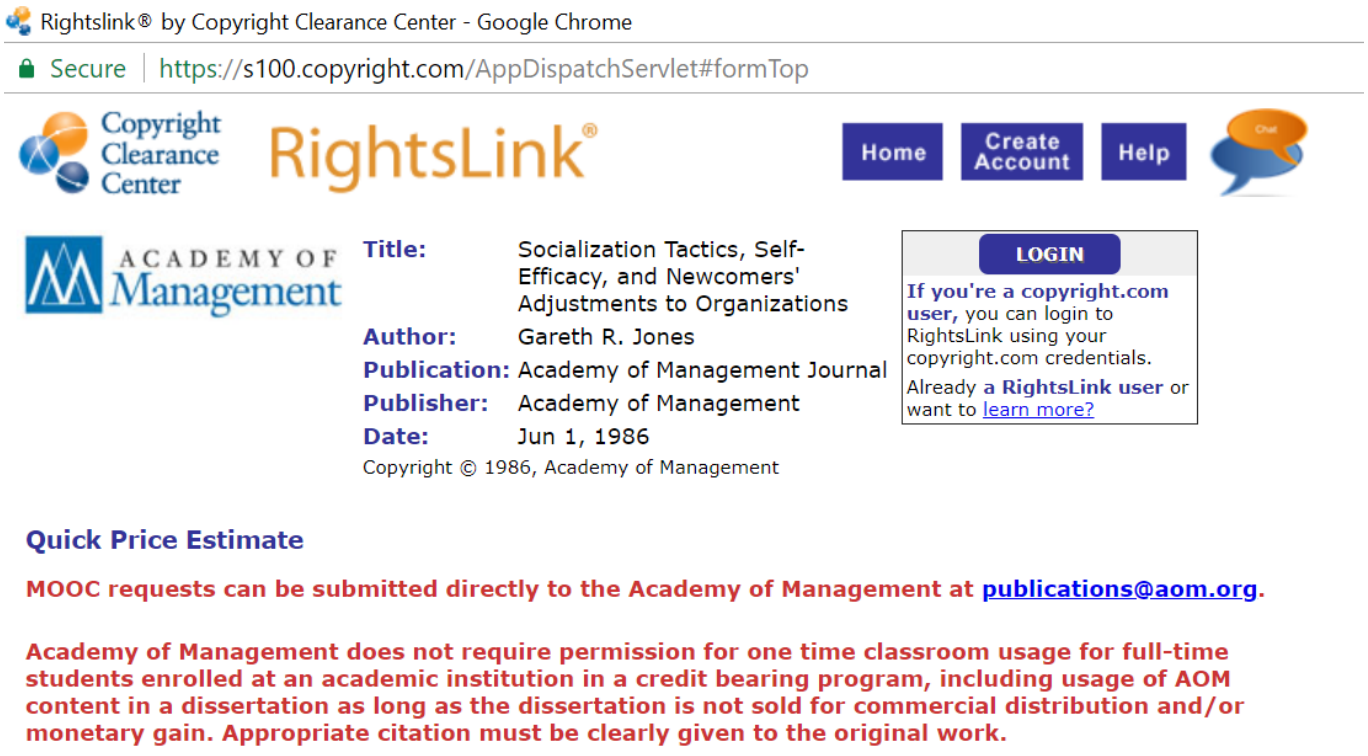
I understand the unique ethical issues associated with military service	❍	❍	❍	❍	❍	❍
I am very knowledgeable about the many services that are available to veterans and their families	❍	❍	❍	❍	❍	❍
I feel well educated about the political issues and the important historical aspects of recent conflicts	❍	❍	❍	❍	❍	❍
Overall, I feel a strong sense of connection to the military and its members	❍	❍	❍	❍	❍	❍

Please rate your degree of confidence by recording a number from 0 to 100 using the sliding scale given below:

0	10	20	30	40	50	60	70	80	90	100
Cannot do at all				Moderately can do					Highly certain can do	

_____ Working effectively with a veteran and their family
_____ Show empathy toward a veteran and their family
_____ Convey an attitude of care and concern for veterans and family members
_____ Create an environment where a veteran will feel that I understand him/her
_____ Establish a warm, respectful helping relationship with a veteran
_____ Listen carefully to concerns of veterans and family members
_____ Provide effective support for a veteran and their family
_____ Assist a veteran or family member understand how I can help them meet their needs
_____ Understand the special issues that veterans and their families have
_____ Communicate unconditional acceptance for veterans and their families
_____ Assist the veteran in modulating feelings about their decision-making process
_____ Know how much to push veterans if they are reluctant to talk about something
_____ Quickly develop rapport with veterans and their families
_____ Effectively express care for the concerns of veterans and their families
_____ Demonstrate attentive and supportive verbal communication with veterans
_____ Demonstrate attentive and supportive nonverbal communication behaviors with veterans
_____ Referring veterans and their families to the most effective sources of help

Appendix C: Permission to Use Content in Dissertation (Socialization Tactics Scale)



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ACADEMY OF Management

Title: Socialization Tactics, Self-Efficacy, and Newcomers' Adjustments to Organizations

Author: Gareth R. Jones

Publication: Academy of Management Journal

Publisher: Academy of Management

Date: Jun 1, 1986

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Appendix D: Socialization Tactics Scale

(Retrieved from Jones, G. R. (1986). Socialization tactics, self-efficacy, and newcomers' adjustments to organizations. *Academy of Management Journal*, *29*(2), 262-279.)

Found in Appendix (pp. 277-279)

Unless otherwise noted, responses were measured on 7-point scales ranging from "strongly disagree" to "strongly agree." (R) indicates reverse scoring.

Scales Measuring Socialization Tactics

Collective versus individual:
CIl In the last six months, I have been extensively involved with other new recruits in common, job related training activities.
CI2 Other newcomers have been instrumental in helping me to understand my job requirements.
CI3 This organization puts all newcomers through the same set of learning experiences.
CI4 Most of my training has been carried out apart from other newcomers. (R)
CI5 There is a sense of "being in the same boat" amongst newcomers in this organization.

Formal versus informal*:*
FIl I have been through a set of training experiences which are specifically designed to give newcomers a thorough knowledge of job related skills.
FI2 During my training for this job I was normally physically apart from regular organizational members.
FI3 I did not perform any of my normal job responsibilities until I was thoroughly familiar with departmental procedures and work methods.
FI4 Much of my job knowledge has been acquired informally on a trial and error basis. (R)
FI5 I have been very aware that I am seen as "learning the ropes" in this organization.

Investiture versus divestiture:
IDl I have been made to feel that my skills and abilities are very important in this organization.
ID2 Almost all of my colleagues have been supportive of me personally.
ID3 I have had to change my attitudes and values to be accepted in this organization. (R)
ID4 My colleagues have gone out of their way to help me adjust to this organization.
ID5 I feel that experienced organizational members have held me at a distance until I conform to their expectations. (R)

Sequential versus random:
SRI There is a clear pattern in the way one role leads to another or one job assignment leads
to another in this organization.
SR2 Each stage of the training process has, and will, expand and build upon the job knowledge gained during the preceding stages of the process.
SR3 The movement from role to role and function to function to build up experience and a track record is very apparent in this organization.
SR4 This organization does not put newcomers through an identifiable sequence of learning experiences. (R)
SR5 The steps in the career ladder are clearly specified in this organization.

Serial versus disjunctive:
SDl Experienced organizational members see advising or training newcomers as one of their main job responsibilities in this organization.
SD2 I am gaining a clear understanding of my role in this organization from observing my senior colleagues.
SD3 I have received little guidance from experienced organizational members as to how I should perform my job. (R)
SD4 I have little or no access to people who have previously performed my role in this organization. (R)
SD5 I have been generally left alone to discover what my role should be in this organization. (R)

Fixed versus variable:
FVl I can predict my future career path in this organization by observing other people's experiences.
FV2 I have a good knowledge of the time it will take me to go through the various stages of the training process in this organization.
FV3 The way in which my progress through this organization will follow a fixed timetable of events has been clearly communicated to me.
FV4 I have little idea when to expect a new job assignment or training exercise in this organization. (R)
FV5 Most of my knowledge of what may happen to me in the future comes informally, through the grapevine, rather than through regular organizational channels. (R)