THE RELATIONSHIP BETWEEN ROLE-TAKING ABILITIES OF HEAD NURSES AND THEIR PERCEIVED LEADERSHIP EFFECTIVENESS

by

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SUPERVISORY COMMITTEE APPROVAL

of a thesis submitted by

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This thesis has been read by each member of the following supervisory committee and by majority vote has been found to be satisfactory.

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FINAL READING APPROVAL

To the Graduate Council of the University of Utah:

I have read the thesis of Dawn Paula Carlson in its final form and have found that (1) its format, citations, and bibliographic style are consistent and acceptable; (2) its illustrative materials including figures, tables, and charts are in place; (3) the final manuscript is satisfactory to the Supervisory Committee and is ready for submission to the Graduate School.

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ABSTRACT

The relationship between role taking, as a component of leadership, and the perception of leadership effectiveness was the focus of this study. Another study evaluated these same variables with individuals from the nursing education setting. This research was conducted with individuals from the nursing practice setting. A convenience sample was taken with head nurses (n = 19) and members of their staff nurses (n = 183) from two Salt Lake City area hospitals. Each individual completed a demographic questionnaire along with selected subscales of the Interpersonal Reactivity Index (IRI). The staff nurses also completed the Leadership Behavior Description Questionnaire-XII (LBDQ-XII). Role-taking ability of the head nurses was measured as the score obtained on the Perspective Taking subscale of the IRI. Their leadership effectiveness was measured by their staff nurses' ratings of leadership behavior on two dimensions of the LBDQ-XII: (a) Initiating Structure scale and (b) Showing Consideration scale. Pearson correlation coefficients were calculated to examine the relationship between the two variables of role-taking ability and leadership effectiveness. Partial correlations also were calculated to control for the possible effect of role taking by the

staff nurses on this relationship.

Initial analysis of the data revealed that 18 of the 19 head nurses were rated as effective leaders by their staff nurses, having average scores above the median on both dimensions of the LBDQ-XII. Correlational analyses indicated that there were no statistically significant relationships between role-taking abilities of the head nurses and the ratings of leadership effectiveness provided by the staff nurses. These same results were obtained when partial correlation analysis was conducted to control for the effect of staff nurses' role-taking abilities.

Some demographic variables did correlate, although only weak to mild, with the variables of role-taking ability and leadership effectiveness. These correlations did not add significantly to understanding the relationship between role-taking ability and leadership effectiveness.

This investigation did not lend support to the results obtained in the nursing education setting. Further study needs to address the relationship between role-taking ability and leadership effectiveness.

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CHAPTER I

STATEMENT OF THE PROBLEM

Introduction

The focus of this study was to look at the relationship between role-taking abilities, as an aspect of leadership, and the perception of leadership effectiveness. This is a replication of research conducted by Mansen (1988). He looked at these same variables in the area of nursing education. This study was conducted in the area of nursing practice.

Statement of Purpose

The purposes of this study were to examine (a) role-taking ability of head nurses and selected staff nurses, (b) leadership effectiveness of head nurses as perceived by staff nurses, and (c) relationship between role-taking ability of head nurses and staff nurses and perceived leadership effectiveness.

Significance of the Study

Many individuals are in nursing leadership due to their clinical expertise or long tenure (Byers & Klink, 1978; Hodges, Knapp, & Cooper, 1987; Lee, 1987; Sanford, 1987). The transition from clinical nurse to first-line

manager necessitates formal preparation (Duckett & Brunette, 1988). Traditionally, when nurses have been promoted, few have been prepared formally in academic programs for administration (Hodges et al., 1987). Once in a management role, they hear complaints that their leadership is inadequate (Lee, 1987).

Nursing management today is presented with new challenges. The advent of diagnostic-related groups (DRGs) in health care has placed an emphasis on cost containment and cost effectiveness (Lee, 1987). Organizations are integrating horizontally with decentralized management. Nurse managers are faced with issues of product-line orientation, quality control, efficacy, efficiency, and productivity (Spitzer & Davivier, 1988). Clichès such as "working smarter not harder" and "doing more with less" describe the tone of nursing management today.

Nursing administrators identify the head nurse as the most crucial link in the hierarchy of nursing management (Hopkins, 1987). The head nurse is in the pivotal position of having the greatest potential to directly affect patient outcomes (Hopkins, 1987). Head nurses are expected to provide innovative leadership and manage material and human resources to produce a high quality of care at a low cost (Hodges et al., 1987). They have responsibilities for personnel management, staff

development, budgeting, setting staffing standards, and staffing the nursing unit with the appropriate numbers and mix of staff necessary to ensure high quality nursing care. The head nurse also deals with issues of professionalism, power, autonomy, interprofessional competition, individual rights, cost containment, costing nursing services, quality assurance, and effects of the prospective payment system (Holle & Blatchley, 1989). This is in addition to maintaining their own professional competency.

Head nurses need to be chosen for their leadership ability as well as clinical competence. As nurse managers advance in administration, the need for clinical skills decreases, while the need for knowledge and skills related to management and leadership increases (Byers & Klink, 1978). Once a nurse is in a leadership position, leadership development is necessary. "The future of the profession of nursing depends on good leadership" (Shores, 1978, p. 103).

Leadership is an elusive and amorphous concept and is difficult to describe in a broad context (McNally, 1986; Shores, 1978). There is no universal definition of leadership (Cohen, Fink, Gadon, & Willits, 1984), but there is general consensus that there are two necessary behavioral components of leadership: (a) an organizational concern with a focus on tasks and (b) a

humanistic concern with a focus on people (French, Kast, & Rosenzweig, 1985; Stevens, 1985).

What then constitutes an effective leader? Effective leadership is defined as a "judgment made regarding the performance of an individual, group or organization. The closer their actual performance is to the desired performance, the more effective we judge them to be" (Gibson, Ivancevich, & Donnelly, 1985, p. 25). Effective leadership is measured by productivity, satisfaction, and cohesiveness (Hollander, 1985). Cohen et al. (1984) stated that different types of tasks, differing leader characteristics, and different types of followers influence what effective leader behavior will be.

In order for leadership to occur, followers are required. Hollander (1985) stated that "the leadership structure is the framework within which the process of leader-follower relations occurs" (p. 485). Leadership can be viewed as a transactional process (Bennis & Nanus, 1985; Hollander, 1985) in which the leader and followers work together in a reciprocal relationship to accomplish mutual goals. "Many of these elements of the transaction between the leader and followers come together in recognizing that in leadership there is a dynamic relationship with followers who perceive and evaluate the leader in the context of situational demands" (Hollander, 1985, p. 502). Followers are just as important to

leadership as are the qualities that the leader may personally possess (McNally, 1986).

The willingness of followers to accept the influence of a leader depends upon an exchange process (Hollander, 1985). This exchange is found in the transactional process. The exchange perspective encourages awareness of the needs of others; cooperation is necessary for this to occur. McNally (1986) stated that "cooperation is based upon a mutually supportive relationship in which each person recognizes that the other has legitimate needs she [he] can satisfy and perceives the other as a means of satisfying her [his] own needs" (p. 382). The transactional relationship involves a two-way influence between the leader and followers, denoting an active role by followers. The leader provides equity and system progress in exchange for esteem and responsiveness. Leaders need to be aware of how they project themselves and of their behaviors that contribute to a positive working environment to promote productive followers.

Role taking is a fundamental leadership characteristic. Leaders who are aware of influences upon leadership and the importance of the leader-follower relationship have the opportunity to engage in role taking. Halsey (1978) described role taking as:

> . . . a process whereby the role incumbent [leader] takes the role of significant others [followers] in a setting. In doing so, the leader develops an attitude of empathy so that she [he] is able to predict how her [his] role communications, and behavior will effect not only herself [himself], but others and society. This process enables the person or actor [leader] to assume a role that is dynamic and that maximizes the needs or goals not only of the actor, but of the significant others in a situation that will produce one single harmonious operational code of behavior. (pp. 248-249)

It is vital that leaders incorporate this critical leadership quality into their leadership role to foster positive relationships among their followers and among themselves. Followers need to role take the position of the leader, but leaders must role take the position of all the followers as well as to be aware of their relations to one another (Kohlberg, 1969).

The literature is supportive of leaders exhibiting behaviors that relate to role-taking ability. However, research on role taking and its relationship to leadership effectiveness is extremely limited. Investigating this relationship is therefore indicated and was the subject of this study. The results will have practical significance for individuals who are in leadership positions or who aspire to leadership positions and who want to exercise effective leadership within hospital nursing settings.

Research Hypotheses

This investigation addressed the following research hypotheses.

Hypothesis 1

> There will be no relationship between self-rated, role-taking abilities of head nurses and ratings of their leadership effectiveness as rated by a sample of their staff nurses, while controlling for possible effects of role-taking abilities of the staff nurses.

Hypothesis 2

> There will be no relationship between role-taking and situational/demographic variables (i.e., organizational characteristics, educational preparation of head nurses and staff nurses, length of time employed in nursing, length of time supervised by head nurses, length of time in supervision for head nurses, degree of professional activity, interaction time between head nurses and staff nurses, and job satisfaction).

Hypothesis 3

> There will be no relationship between leadership effectiveness and situational/demographic variables (see Hypothesis 2).

Conceptual Framework

The conceptual framework is identical to that used by Mansen (1988), with the exception of different demographic variables. The concepts of role-taking ability and leadership effectiveness are discussed in depth in Chapter II, Review of Literature, as they pertain to this study. This framework is diagrammed in Figure 1.

Demographic variables:

1. Organizational characteristics
2. Educational preparation
3. Length of time in nursing
4. Length of time in supervision (for head nurse)
5. Length of time supervised by head nurse (for staff nurse)
6. Degree of professional activity
7. Interaction time between head nurse and staff nurse
8. Job satisfaction

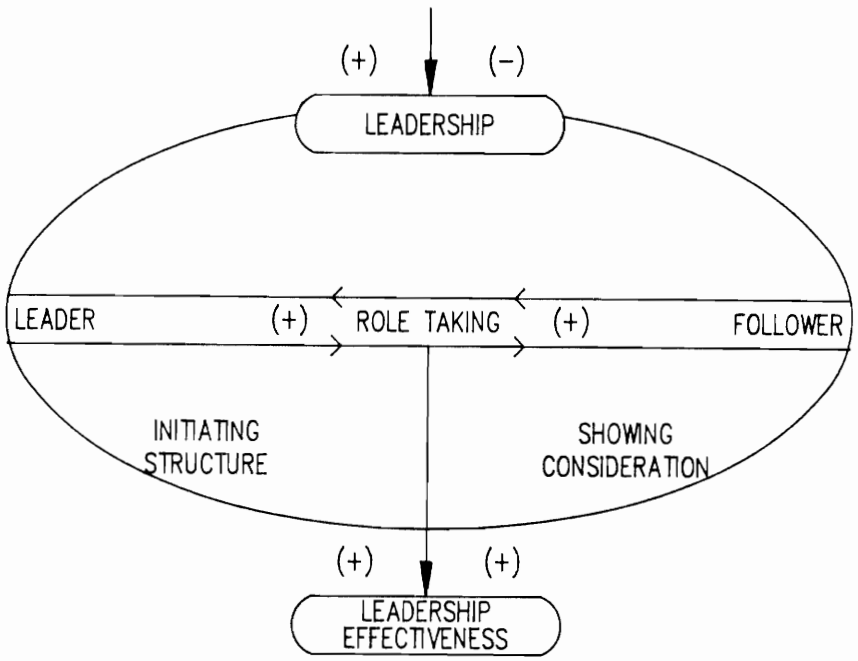

Figure 1. Conceptual framework.

Note. Role taking is perceived as a factor that mediates a transactional leadership relationship between the leader and follower. Variables that are perceived to influence leadership are placed outside the circle, impacting upon both leader and follower.

Definitions

For purposes of this study, the following definitions were used:

Head nurse (leader) is a registered nurse who is the appointed leader of a hospital nursing unit with the following responsibilities: (a) management of personnel and human resources with duties to include to lead, facilitate, evaluate, communicate, set priorities, assign responsibilities, motivate, and provide for continuing acquisition of knowledge and skills for staff; (b) technical operational duties to include budgeting, staffing, scheduling, assessing physical space of nursing unit, and evaluating supplies used; and (c) management of patients to ensure that quality nursing care is administered. This individual shall have been in the current head nurse position for a minimum of 1 year.

Staff nurse (follower) is a registered nurse or a licensed practical nurse who reports to a head nurse with the above responsibilities, whose main responsibility is that of providing patient care. This individual shall have been employed as a staff nurse reporting to the head nurse in the study for a minimum of 6 months.

Role taking, also referred to as "perspective taking," is a component of empathy, specifically cognitive empathy, in which a person attempts to understand, perceive, or experience the emotional, social, or physical

aspects of a situation from the viewpoint of another person or persons and subsequently alters his or her own behavior and responses to that situation. In this study, role-taking ability is identified as a score obtained on the Interpersonal Reactivity Index (IRI) scale.

Leadership effectiveness is the staff nurse's perception of the leader's competence and fairness in accomplishing the following: (a) delineating relationships between the head nurses and staff nurses and establishing well-defined patterns of organization channels in communication and methods of procedure (i.e., initiating structure); and (b) maintaining an environment of friendship, warmth, interest, respect, and trust in the relationships between the head nurse and staff nurse (i.e., showing consideration). In this study, leadership effectiveness is measured by scores obtained from the two subscales (i.e., Initiating Structure and Showing Consideration) of the Leadership Behavior Description Questionnaire-XII (LBDQ-XII).

Assumptions

For purposes of this study, the following assumptions were made:

1. Leadership is a transactional process involving a dynamic reciprocal relationship between the leader (i.e., head nurse) and followers (i.e., staff nurses).

2. Initiating structure and showing consideration

are two primary leadership behaviors in hospital nursing units.

3. Leaders may use a variety of approaches and/or theories in providing leadership.

4. Head nurses and staff nurses will make a sincere effort to provide valid responses when completing the questionnaires used in this study to measure role-taking ability and leadership effectiveness.

5. Staff nurses are capable of evaluating and rating leadership effectiveness.

6. Self-reported cognitive empathy is a valid measure of role-taking ability in practice.

Limitations

For this study the following limitations were recognized:

1. This study did not measure the head nurse's leadership style or other personality factors that may influence the staff nurse's perception of leadership effectiveness.

2. This study did not measure the socialization processes of leader and follower either professionally or personally that may affect their ability to participate in role taking.

3. Leadership was narrowly defined and measured only in the two primary dimensions of initiating structure and showing consideration.

4. The generalizability of the study was limited to the population that was included in the study.

Summary

In this first chapter, an introduction of the study was presented. The statement of the problem included the statement of purpose, significance of the study, research questions, conceptual framework, definitions, assumptions, and limitations. Chapter II provides the review of the relevant literature.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

The review of literature is organized into three main sections. It is organized to coordinate with the conceptual framework as diagrammed in Chapter I. The first section presents the concept of empathy and its characteristic relationship to role taking, as well as leadership. The second section discusses the development of role taking. Last, the third section addresses leadership and leadership effectiveness and ends with a conclusion.

Empathy

Historical Roots of the Concept

Review of the literature revealed a lack of consensus for an operational definition of the term "empathy." There is agreement from different conceptualizations that empathy requires determination of self and its relation to others and is a response to another's affective state. Disagreement centers around whether empathy is cognitive, affective, or both and what the processes that explain empathy are. Different disciplines have analyzed

different aspects of the concept. Explaining the historical roots of empathy leads to greater understanding of the complexities of this concept. The following historical roots of empathy are discussed: (a) aesthetic, (b) sociological, (c) social-psychological, (d) developmental psychological, and (e) counseling/ psychotherapy.

The aesthetic process refers to artistic creation or why one experiences something as beautiful. Robert Visher is credited with being the first person to use the term "einfuhlung" in 1893 (Gladstein, 1984). This German terminology translates to English as "empathy." In 1897, Theodor Lipps, using the term "einfuhlung," was identified as the creator of the concept of empathy due to his extensive and detailed writings, even if he was not the first to identify the term "einfuhlung" (Deutsch & Madle, 1975). In 1909, Titchener translated Lipps' notion of "einfuhlung" as empathy in order to preserve the idea of the self-projected into the perceived object (Wispe, 1986). The concept was introduced by Lipps as a way to understand foreign objects (i.e., works of art). Fifteen years later Lipps altered his earlier view to include empathy as a response to a person, rather than just an object. Lipps viewed empathy as a subjective experience, which became objective (or known to the empathizer) only after the activity was contemplated in retrospect

(Gladstein, 1984). There was agreement among the aesthetic empathy writers Lee, Groos, Worringer, and Lipps that people project their own thoughts and feelings onto inanimate objects and other humans. This was a kind of animism (Gladstein, 1984).

The sociological roots of the concept "empathy" stem from the writings of Cooley and Mead. Charles H. Cooley was a sociologist who drew on the ideas of philosophers-psychologists. As noted in Gladstein (1984), Cooley described sympathy as a "sharing of any mental state" (p. 44). This was similar to some of the aesthetic empathy writers. Cooley later denoted the difference between sympathy and compassion. He defined sympathy to be similar with other writings of empathy. Cooley also wrote of the "social self." Cooley's writings were important to George H. Mead who is the most noted sociologist regarding the origins of the role-taking view of empathy (Gladstein, 1984). Mead took Cooley's view of sympathy further. He described it in role-taking terms as "putting yourself in his [her] place" (Deutsch & Madle, 1975). In addition, Mead differentiated between sympathy and "putting yourself in his [her] place." Although he did not use the term empathy, this became the source for the role-taking views that emerged in later literature. Mead is noted for describing the affective and cognitive components of empathy, reference to the environment, and self/other

differentiation (Deutsch & Madle, 1975).

The social-psychological roots came from writings of Cottrell, Wundt, McDougall, Allport, and Heider. Their writings denote a distinction between empathy and sympathy for the social-psychology discipline (Gladstein, 1984). Empathy occurs when an observer has a similar thought or emotion to the individual observed. Sympathy indicates feeling sorry for another. Cottrell labeled interactions described by Cooley and Mead as empathy, not as sympathy as the sociologists had done. Cottrell called for new research approaches and for a situational frame of reference (Gladstein, 1984). Wundt was a physiological psychologist whose writings on ethics influenced the social-psychology literature. His writings on sympathy were discussed in the context of man's social development. He believed that sympathy was one's own emotions, grown objective (Gladstein, 1984). This view was similar to the process that Lipps wrote about. Rather than projecting emotions onto an object, Wundt believed that the other person's emotions are taken into the empathizer. McDougall was a scholar of the affective or contagion view of empathy. He was interested in the emotional reactions of one individual observing another. He wrote distinguishing simple or passive sympathy from active sympathy, active sympathy being important to altruism and being valuable in stimulating social cooperation for

social ends (Gladstein, 1984). Allport was another early social psychologist who wrote about sympathy and emotional reactions. He made a radical departure from existing theories, believing that conditioning, as opposed to instincts, made up the basis of sympathetic behaviors. He maintained that prior learning affected the empathic experience. Heider developed a theory of interpersonal relations that also looked at sympathy and its relation to emotional reactions. He made a distinction between pure sympathy and emotional contagion, noting that cognitive elements, while not dominant, may be present.

Jean Piaget is the most prominent writer of the early developmental psychological root of the term empathy. Although he did not use the term empathy, his term "decentering" came very close. His ideas about sympathetic tendencies, egocentrism, and decentering were labeled by later developmental psychologists as empathy and role taking. Piaget believed that the child needed to develop past egocentrism (i.e., the inability to view the world from another's viewpoint) before any role taking could occur (Gladstein, 1984); this does not happen until the child is past age 7 or 8. Piaget did not believe that decentering (i.e., empathy) could be separated into intellectual and emotional processes. He believed they were one.

The last roots for the term empathy came from the

counseling/psychotherapy literature. These ideas seemed to evolve independently from the other roots. Some of these clinicians described empathy similarly to the existing literature, but they also developed ideas that were quite different (Gladstein, 1984). Two streams of thought came from this root: (a) identification and (b) role-taking aspects of empathy. Each one is addressed separately.

The identification stream of the counseling/psychotherapy literature began with Freud. He believed that identification was the earliest expression of an emotional tie with another person. Imitation was the second step of the process and empathy was the third step towards taking the attitude or feelings of another. Sullivan, Reik, Stewart, and Kohut developed more fully Freud's original ideas (Gladstein, 1984). Sullivan applied the term empathy to a theorem he put forth regarding how the infant becomes anxious through empathy when anxiety is present in the mothering one. It has been referred to as a "psychological umbilical cord" (Deutsch & Madle, 1975); this suggests the affective aspect or emotional contagion perspective of empathy. Reik's interest in empathy was centered around the therapeutic encounter. He wrote of "vicariously" living the patient's experiences, while at the same time observing the experiences as a factual "investigator" (Gladstein, 1984). He wrote that the

therapist needs to listen with the third ear. Reik did not label this process as empathy, but Stewart did. Stewart wrote that through empathy we learn more about ourselves. He called this "personal knowing." He viewed empathy as a deliberate and multifaceted process. Kohut viewed empathy as not only crucial to the psychotherapy process but important to human relationships in general. He referred to empathy as the human echo to human experience.

For the role-taking stream of the counseling/psychotherapy root, Rogers has been the most influential. He obtained a unique perspective from two therapists who preceded him, Rank and Taft (Gladstein, 1984). Rank is known for his "will therapy." He used the term "will" to mean a unique source of energy that facilitates health. The "will-to-health" struggles with its counterwill. The therapist is on the side of the counterwill; thus, patients can act on their own will. Taft wrote of a "relationship therapy," emphasizing understanding and acceptance as opposed to interpretation or analysis. Her emphasis is on forming a relationship that allows the forces or will of the patient to function. Rogers is known for his "nondirective" or "client-centered" therapy. This involves not only seeing the world as the client sees it but also explaining this "seeing" back to the client. He emphasized role-taking or an "as-if" quality, rather

than the emotional reaction or contagion view of empathy.

The controversy over whether empathy is affective or cognitive, or both, can still be seen in the literature today. The research and measurement of empathy have been done according to which paradigm of thought and discipline an individual ascribed to. More recently, Davis (1983) viewed empathy from a multidimensional approach, measuring both the affective and cognitive aspects. This type of approach can broaden the understanding of the concept and facilitate research and measurement of it (Chlopan, McCain, Carbonell, & Hagen, 1985; Davis, 1983).

Research and Measurement of Empathy

As discussed previously, the research of empathy was based on the particular discipline and the viewpoint of empathy as either affective or cognitive. Synonyms for affective empathy have been listed as identification, emotional reaction, emotional contagion, resonation, and "I feel what you feel" (Gladstein, 1983). Cognitive empathy has been referred to as role taking, perspective taking, predictive, communicative, and "I comprehend what you feel." Each discipline has its own empathy literature, its own models of empathy, and its own measures of empathy (Gladstein, 1983). A review of literature from the developmental, social psychology, and counseling disciplines shows 20 different measures. A

majority of empathy measures is based on the cognitive view (Chlopan et al., 1985), which is based on a definition of empathy involving prediction and accuracy. An individual's accuracy in predicting the self-rating or preferences of others' thoughts, feelings, or actions is involved with predictive measures (Deutsch & Madle, 1975). There are three popular empathy measures based on the cognitive paradigm of empathy. These are Dymond's (1949) "Rating Test," Kerr and Speroff's (1954) "Empathy Test," and the "Hogan Empathy Scale" (Hogan, 1969).

Dymond's (1949) "Rating Test" was designed to determine how well an individual can transpose himself or herself into the thoughts, feelings, and actions of others. If this could be done, the individual should be able to predict how others will behave in certain defined situations. This test involved having an individual (a) rate himself or herself, (b) rate another individual, (c) rate the other individual as believed he or she would rate himself or herself, and (d) rate himself or herself as believed the other individual would rate him or her. This was done on a 5-point scale for each of six traits: (a) superior/inferior, (b) friendly/unfriendly, (c) leader/follower, (d) self-confidence, (e) selfish/unselfish, and (f) sense of humor (Dymond, 1949). She later revised the test to replace the last three traits with shy/self-assured, sympathetic/nonsympathetic,

and secure/insecure. Smaller differences between each set of total scores portray higher convergence or self/other empathy being reflected (Deutsch & Madle, 1975). Dymond found that empathy is possessed in different degrees by different people and that the development of empathy is a result of life experiences (Bucheimer, 1963). Data obtained by use of the Dymond "Rating Test" may be influenced by such artifacts as cultural stereotypes, intuition, identification, and projection (Bender & Hastorf, 1953; Bucheimer, 1963; Chlopan et al., 1985; Deutsch & Madle, 1975; Guiora, 1967; Hogan, 1969). Projection is particularly damaging to the measurement of empathy. Hobart and Fahlberg (1965) defined projection as the attribution to another of one's own needs, interests, and attitudes. This process of projection is contrary to empathy. In addition, Chlopan et al. (1985) pointed out that administration of the Dymond "Rating Test" usually requires more than 2 hours, further detracting from the use of this empathy measure.

The "Empathy Test" (Kerr & Speroff, 1954) was developed so that individuals could rank how they thought the average person would rank the popularity of various musical forms, national circulation of different magazines, and annoyance value of different experiences (Chlopan et al., 1985; Deutsch & Madle, 1975). The test was designed to measure an individual's ability to

anticipate certain typical reactions of defined normative persons. This measure failed to correlate with Dymond's (1949) "Rating Test" (Chlopan et al., 1985). Hall (1965) cited numerous negative features of the "Empathy Test" and stated "the test is more a measure of general information and prediction of opinions than of interpersonal empathy" (p. 215).

The "Hogan Empathy Scale" (Hogan, 1969) was designed to measure the ability of an individual to put oneself in another person's shoes. An empathy criterion was produced to create the scale using Q-sort descriptions of highly empathic individuals furnished by various experts (Forsyth, 1979). Hogan (1973) believed that the concept of empathy is central to understanding moral development:

> When a person acts from the moral viewpoint, he [she] tries to consider the implications of his [her] actions for the welfare of others. The disposition to take the moral point of view is closely related to empathy or role taking. (p. 222)

Hogan (1969) cited the following five items as most descriptive of a highly empathic individual:

(a) is socially perceptive of a wide range of interpersonal cues;
(b) seems to be aware of the impression he [she] makes on others;
(c) is skilled in social techniques of imaginative play, pretending and humor;
(d) has insight into own motives and behavior; and
(e) evaluates the motivation of others in interpreting situations. (p. 309)

Grief and Hogan (1973) stated that "an empathic disposition heightens one's sensitivity to the expectations of others and consequently engenders social compliance, an important aspect of moral behavior" (p. 280). People who are more empathic possess keen insight, imaginative perceptiveness, and should be better adjusted, more socially aware, and more caring about the feelings of others (Chlopan et al., 1985; Forsyth, 1979). This closely parallels role taking.

The affective paradigm of empathy also is referred to as "empathic emotional responsiveness." While the cognitive role-taking process is the recognition of another's feelings, the affective emotional process includes sharing those feelings, whether pleasant or unpleasant, at least at the gross-affect level (Mehrabian & Epstein, 1972). Fewer measures exist to evaluate affective empathy as compared to cognitive empathy. These measures typically rely on self-reports or physiological indicators based on a subject's empathic response to a person's affect, situation, or both (Deutsch & Madle, 1975). Affective empathy was commonly measured by the use of real-life situations, photographs, audio-recordings, or video-taped interaction encounters (Deutsch & Madle, 1975). Subjects were asked either to label correctly the affective response portrayed or to respond with a statement of how the subject felt when observing another's

affect.

Measuring the affective responses did not always produce consistent results or adequate validity. Low validity of self-ratings is due to confounding variables and response styles (Mehrabian & Epstein, 1972). Stotland (1969) reported a lack of consistency among several self-report measures of empathy, vasoconstriction, and palmar sweating. The physiological measures were inadequate due to their inability to differentiate various aspects of emotional experience (Mehrabian & Epstein, 1972).

Mehrabian and Epstein (1972) developed a measure of affective empathy that does not depend on physiological variables. It is a self-report instrument known as the Questionnaire Measure of Emotional Empathy (QMEE). This instrument measures emotional empathy as it relates to helping behavior and aggressive behavior (Chlopan et al., 1985). Their findings showed that empathic tendency is the leading personality determinant of helping behavior. In addition, empathic tendency was found to inhibit aggressive behavior, although not significantly.

From a review of studies looking at moral conduct and character using the QMEE, it was found that high scorers on the QMEE are more socially aware, have higher moral development, and volunteer more to help others than those who score low (Chlopan et al., 1985). Kalle and Suls (1978) examined the relationship between emotional empathy

and moral reasoning. They found that a purely cognitive approach, or role-taking ability, may better facilitate advanced moral reasoning.

There has been considerable controversy over whether empathy should be viewed as cognitive or affective, or both. Researchers have begun to view empathy as a multidimensional concept that consists of both cognitive and affective domains. This led Davis (1980) to develop the IRI which measures both aspects of empathy. Each aspect of empathy is broken into two subscales on this instrument, which results in four separate subscales to measure empathy. Cognitive empathy is measured by the Perspective Taking (i.e., another term for role taking) subscale and the Fantasy subscale. Affective empathy is measured by the Empathic Concern subscale and the Personal Distress subscale. The IRI has been shown to correlate well with both the "Hogan Empathy Scale" that measures cognitive empathy and the QMEE that measures affective empathy (Chlopan et al., 1985).

The IRI has undergone considerable testing, primarily regarding distinguishing between affective and cognitive aspects of empathy. Bernstein and Davis (1982) looked at perspective taking, self-consciousness, and accuracy in person perception. They found that scores on the Perspective Taking scale are a significant predictor of accuracy in perceiving others.

In another study, Davis (1983) looked at the effects of individual variation in empathic tendencies as a factor to influencing emotional reactions and helping. Two subscales of the IRI were used as measures of individual differences in empathy: Perspective Taking and Empathic Concern. Subjects were tested on these scales and were given instructions either to adopt the perspective of the person they would hear on a tape or just merely to listen. The tape was a recorded appeal for help from a young woman. After hearing the tape recording, subjects completed a questionnaire assessing their emotional reactions and were given an opportunity to help the woman they had heard on the tape. Results of this study are that individual differences in empathy can influence empathic emotion and personal distress, even more than the influence of situational factors (Davis, 1983). In addition, it was found that this effect of individual differences is due to emotional, not cognitive, empathy (Davis, 1983). It also was determined that Perspective Taking scores can predict behavior better than Empathic Concern scores when the behavior under investigation is not an emotional reaction or an act strongly affected by emotional reactions. These results provide support for a multidimensional view of empathy.

In a more recent study, Davis, Hull, Young, and Warren (1987) investigated the influence of cognitive and

emotional empathy on emotional reactions to dramatic film stimuli. They used clips from Brian's Song to elicit feelings of sadness and sympathy and Who's Afraid of Virginia Wolf to elicit feelings of anger and hostility. Prior to viewing the film, subjects were asked to complete the IRI and were given instructions for viewing the film. After viewing the film, subjects completed a questionnaire concerning their emotional reactions to the film. The results of this study were consistent with a multidimensional view of empathy in that subjects exhibited the two types of empathy (Davis et al., 1987). Positive emotional reactions were associated with cognitive empathy, and negative emotional reactions were influenced by emotional empathy.

Empathic Process

Being aware of the empathic process and knowing the value of practicing empathy are needed to understand the concept of empathy. The empathic process can be referred to as sharing of another's emotions (Stotland, 1969). Smither (1977) took this further to describe the empathic process as an exchange or sharing of feeling and/or experiences between individuals. Shackelford (1985) paraphrased the stages of the empathic process first identified by Riek as follows:

> Stage 1. Identification; this is the first and essential phase in the sequence of empathy. It is the process of losing consciousness of the self and becoming engrossed in the experiences and situation of another. Through the relaxation of conscious control, absorption in the other person and his [her] experience is achieved. It is not a conscious event but occurs spontaneously.
>
> Stage 2. Incorporation; this second phase refers to actually taking the experience of the other person into oneself. It differs from identification in that identification is a projecting of the self into the experience of the other, while incorporation means literally "taking on" the feelings of the other person. The end result is that there is greater connectedness between the empathizer and the presenting other.
>
> Stage 3. Reverberation; in reverberation, the third phase in the empathic process, there is a resonance between the two experiences; that is, the experience of the empathizer and the presenting other. It is here that the greatest insight is obtained into the experience of the other. The identity of the empathizer is not lost but resonates experientially with the other.
>
> Stage 4. Detachment; in this final phase, the empathizer withdraws from subjective involvement and resumes an objective stance. The insight gained from the phase of reverberation added to reason and objectivity allows for useful responses. It is here that numerous intellectual resources are drawn upon the empathizer to deal with the presenting other's unique situation. It is in the detachment phase that validation, exploration and problem solving most likely occur. It is this phase of empathy which renders the process especially growth promoting for the presenting other. (pp. 3-4)

Practicing empathy and using the empathic process produce beneficial outcomes for both individuals involved in the process. Empathy provides occasions for growth and development for all involved in the empathic process. Viewed from a role theory perspective, empathy resembles

role taking and promotes the development of interpersonal and social skills, thereby contributing to the socialization process of those individuals involved (Cottrell, 1969; Hurley, 1978). By participating in role-taking activities, one is able to develop oneself personally. Before taking on the role of another, one must first develop an awareness of self (Wispe, 1986). This allows an individual to be objective and not detach or withdraw from situations.

Empathy is a way of gaining knowledge or understanding individuals and/or situations (Carper, 1978; Guiora, 1967). According to Carper (1978), empathy is a significant mode of knowing related to the esthetic pattern of knowing. Esthetic knowing involves giving meaning or denoting importance to one's understanding of another's behavior. Empathic knowing allows one to perceive others and understand situations from a different viewpoint. Empathy provides a larger repertoire of choices available in decision making to produce effective and satisfying results. Even though empathy increases the complexity and difficulty in making decisions, it allows those with an empathic understanding to make more rational decisions (Carper, 1978). Understanding individuals and situations, as well as making rational decisions, is important. This makes empathy paramount to the concept of leadership.

Empathy and Leadership

Some descriptions that are characteristic of leaders also are characteristic of empathy. Stogdill (1974) reports on leadership studies that characterized leaders as having insight into the motives, thoughts, feelings, and actions of others. Social insight is one variable that researchers have used to study leadership. "Empathy and insight can refer to awareness and understanding of social phenomena at a general level, knowledge of cultural norms, social intelligence, or understanding of the most probable tendencies of generalized others" (Bass, 1981, p. 112). The measures that were developed were comparable to cognitive empathy measurement by requiring accuracy in predicting a group response to measures of various characteristics, i.e., job satisfaction, attitudes, and personality (Stogdill, 1974). Chowdhry and Newcomb (1952) found that leaders were more accurate than nonleaders in predicting group responses or norms for a general population. Contrary to the findings of Chowdhry and Newcomb, Hites and Campbell (1950) concluded that leaders were not significantly more accurate in predicting group opinions than nonleaders. However, the population studied by Hites and Campbell was fraternities. This group was probably too homogeneous to permit much contradictory opinion. In addition, fraternity members intermingle so continuously that most everyone in the group knows the

opinions of the others.

Exline (1960) investigated leadership behavior as it relates to social insight (i.e., empathy). Exline's results support Chowdhry and Newcomb (1952) who indicated that researchers should evaluate concerns and judgments that are not common to the group when examining predictive accuracy. Exline found, as did Chowdhry and Newcomb, that a positive relationship between accuracy of social perception and sociometric status was more likely to occur when group goals were the same.

Gallo and McClintock (1962) also looked at leadership behavior and social insight (i.e., empathy). They found that when placed in a leadership role under experimental conditions, individuals who have had previous leadership experience are more accurate in leadership status perceptions than those individuals who have not had previous leadership experience.

In a study of group opinion formation and leader's ability to predict the group opinion, Talland (1954) found that leaders do not differ from followers before group discussion occurs. However, when a group discussion does occur to determine the group's opinion, the leader is better able to predict the group's opinion. This is due to the leader being able to have some influence in shaping and determining the opinion he or she was asked to predict.

Fleishman and Salter (1963) examined the relationship between leader behavior and empathy towards subordinates. They measured two dimensions of leadership behavior: (a) initiating structure and (b) showing consideration. Results were a positive correlation (.40) between empathy and consideration, but not a statistically significant correlation between empathy and initiating structure.

The research studies referred to above were based on the trait theory of leadership and accurate predictions of empathy. These studies viewed empathy as a quality that the leader possesses, thus separating the leader from the follower. Empathy was not considered a process that could be practiced to strengthen leadership effectiveness and enhance the leader's relationship with the followers. Stogdill (1974) pointed out that the operational definitions of the concepts of empathy and insight are not compatible with their theoretical definitions; this contributes to the methodological difficulties.

In summary, the concept of empathy has interested researchers for a considerable length of time. The terminology of sympathy and empathy has sometimes been used to refer to the same concept, thus resulting in confusion (Wispe, 1986). Empathy has historically been viewed as either affective or cognitive. Recently, a multidimensional view consisting of both affective and cognitive domains has gained popularity. The cognitive

component of empathy is directly related to role taking or perspective taking.

Empathy also is related to leadership research. Much of this was based on the trait theory of leadership, which has not been proven worthwhile. This focus does not examine the relationship between leaders and followers. It is this relationship that Meyer, who is quoted in Smith, Jaffe, and Livingston (1955), referred to when he stated "good leaders perceive others as individuals with motives, feelings and goals of their own, whereas poor leaders are more likely to perceive others in relation to their own motives and goals" (p. 386). Undoubtedly, additional research is needed to explore the relationship that empathy and role taking have on the relationship between leaders and followers.

Role Taking

Symbolic Interaction Perspective of Role Taking

Role taking originates from the symbolic interaction perspective of role theory, specifically from the work of George Herbert Mead. Role theory consists of a collection of concepts and an array of hypothetical formulations used to predict how actors will perform in a given role, or under what conditions certain types of behaviors can be expected (Conway, 1978). The term "role" refers to a pattern that can be seen as the consistent behavior of a

single type of actor (Turner, 1962). Every role is a way of relating to other roles. A role cannot exist in isolation. The symbolic interactionist explanation of roles and role behavior focuses on the meaning that the acts and symbols of actors have for each other during the interaction process (Conway, 1978). Role enactment or role performance is a two-way, interactional process. The interaction that is involved in role taking is constant between the role incumbent (i.e., the individual who occupies a role) and those individuals involved in the creation, development, and facilitation of a role. This process contributes to the socialization of individuals for assuming and enacting role behaviors (Hurley, 1978).

Role taking is defined as "the process of anticipating the responses of others with whom one is implicated in social interaction" (Stryker & Statham, 1985, p. 324). Turner (1962) described role taking as that which "shifts emphasis away from the simple process of enacting a prescribed role to devising a performance on the basis of an imputed other-role" (p. 23). The actor is not supplied with a neat set of rules but must act on the perspectives supplied in part by his relationship to others. Generally, role taking focuses on one's ability to view situations from the perspectives of other individuals and the ability to analyze one's own behavior from new perspectives. This leads to subsequent revisions

to one's own role, incorporating part of the other's role even if that role is not appropriate for oneself. Heiss (1968) succinctly described role taking as "informed guessing."

To enable one to participate in role taking, Heiss (1968) described three modes by which one can gain information: (a) direct instruction, (b) observation as a participant during interactions, and (c) observation from the bystander perspective. These methods enable one to acquire information, knowledge, and insight into the reactions of others and their behaviors. Factors exist that influence one's ability to participate in role taking. These are (a) the extent of one's social experiences; (b) the opportunities available to experience a particular role as an actor, other, or observer; (c) the ability to adequately remember particular experiences; (d) the recency of relevant experiences; and (e) the degree to which one paid attention during the interaction (Hurley, 1978).

Accurate role taking depends, in part, on the common symbols that common experience creates. Accurate role taking is not necessarily followed by cooperative or smooth interpersonal relations. "Conflict may sharpen the accuracy of interpersonal perceptions as well as result from such accuracy" (Stryker & Statham, 1985, p. 325).

Role taking involves anticipating the responses of a

particular other person. Mead used the term "generalized other" to imply that many social acts occur in the framework of organized systems of action. "To take the role of the generalized other is to see one's behavior as taking place in the context of a defined system of related roles" (Stryker & Statham, 1985, p. 325). Each experience with taking the role of the generalized other will lead to improved role taking and increase one's mastery in future efforts (Heiss, 1968).

When placed in a situation that one has not previously experienced, one is put in the position of anticipating the responses of a differentiated, yet interrelated, set of others. To respond appropriately, one must be able to distinguish between past and present situations. This distinction allows one to develop hypotheses regarding differences and then to correct behaviors to fit the new situation (Hurley, 1978). Trial and error is the process by which one accomplishes this (Heiss, 1968).

Role Taking and Socialization for Roles

Roles are learned between individuals through reciprocal interactions occurring during the socialization process. Socialization refers to the processes by which an individual learns or acquires the behaviors, values, responses, and skills of a group through exchanges with

other individuals within the group. By learning the appropriate and acceptable roles, one is able to function and become a contributing member of a group.

Role behavior is not a passive but a dynamic process. This process is a result of role reciprocity and interaction.

> Role behavior changes according to varying circumstances and the perceptions/expectation[s] encountered in interactions with relevant others. Interaction is always a tentative process, a process of continuously testing the conception one has of the role of the other. (Turner, 1962, p. 23)

Thus, an individual develops a performance of a role based upon the perceived expectations of others.

The messages sent from the role sender, as well as role pressures, affect one's perceptions of a role. Role pressures are attempts by the sender to influence the receiver to comply to the sender's own role expectations. The resultant behavior of the receiver can be described as the correlation between the received role (i.e., perception) and sent role (i.e., expectation). These roles are dependent upon the content of the messages, the properties of senders and receivers, and the overall environment. When role pressures are experienced, psychological feelings are detected within an individual and are thus identified as role forces. There are also individual forces that consist of one's own set of motivational forces that determine role behavior. These

individual forces may or may not be equal in direction or force to role pressures. One may become strongly resistant or react differently or opposite to the behavior the other expects if one experiences negative or coercive role pressures.

Role conflict may develop when one experiences opposing role forces. This role conflict may obstruct the relationship with the role sender. This type of deteriorating relationship is characterized by weak bonds of respect, trust, and attraction (Kahn, Wolfe, Quinn, & Snoek, 1964). Role conflict not only is emotionally and interpersonally exhausting, but also can be costly to the employer who depends on effective collaboration and coordination.

Role conflict also can result from environmental factors. Aspects of the environment that can produce conflict are (a) organizational structure, (b) personality characteristics of individuals or demographic factors, and (c) characteristics of interpersonal relationships (Kahn et al., 1964).

Role strain, a broader term than role conflict, includes role conflict as well as other situations that might produce role conflict. Role strain results from uncertainty of what one's role involves and which behaviors are appropriate (Lawless, 1972). It is a subjective state of distress (Hardy, 1978).

Role taking is a strategy that minimizes and/or eliminates the factors that contribute to role strain (Hardy, 1978; Stancato, 1974), thereby producing a positive interaction and an overall facilitative environment for productivity and personal/professional development. The process of role taking is necessary for this skillful interaction (Hardy, 1978). "The more clarity and consensus about roles, the easier it is to conform, and hence, the smoother the interaction" (Lawless, 1972, p. 285).

Role-Taking Development and Role-Taking Theory

Socialization for learning roles progresses through developmental stages of the life cycle with a broad exposure to various roles (Hurley, 1978; Sarbin, 1943). The more exposure to differing roles, the more opportunity to practice role taking, which increases the number of roles in one's repertoire. Role taking becomes the sine qua non of the socialization process (Meleis, 1975).

The ability to role take begins with the development of the self (Hurley, 1978). The self is not present at birth but begins to emerge as the individual experiences interactions with significant others. In the beginning, roles are perceived more from an egocentric perspective, but as one develops through the socialization process, one becomes cognizant of others within his or her immediate

environment and begins to learn how to role take. "The development of perspective taking [role taking] is a matter of the child gradually abstracting from social experience an increasing reflective awareness of self and other" (Light, 1983, p. 15). Role taking is often associated with Piaget's stages of cognitive development and Kohlberg's stages of moral development (Keller, 1976; Kurdek, 1977; Moser, 1984; Muuss, 1982; Sommers, 1984; Vikan, 1981). The closest association is seen between role taking and decentration, which occurs in Piaget's stage IIIA--the beginning of formal concrete operations (Muuss, 1982). Decentration is frequently described as "seeing the world through another's eyes" and is thus contrasted with egocentrism (Sommers, 1984). It is hypothesized that role taking, like empathy, cannot result until an individual is able to decenter oneself.

Selman, as reported in Muuss (1982), developed a theory of role taking stemming from the developmental concept of social cognition. Selman was influenced by Mead, Piaget, and Kohlberg. Selman's basic theoretical assumption was that the unique aspect of social cognition and judgment that differentiates human from subhuman functioning is role taking. He defined role taking as "the ability to understand the self and the other as subjects, to react to others as like the self, and then react to the self's behavior from the other's point of

view" (Muuss, 1982, p. 506).

There are five distinct, logically related, developmental stages for the development of role-taking ability. These stages are identified as follows:

> Stage 0. The egocentric undifferentiated stage (approximately age 3 to 6)
> Stage 1. The differentiated and subjective perspective taking stage (age 5 to 9)
> Stage 2. Self-reflective thinking or reciprocal perspective taking stage (age 7-12)
> Stage 3. The third person or mutual perspective taking stage (age 10-15)
> Stage 4. The in-depth and societal perspective taking stage (age 12 to adulthood). (Muuss, 1982, p. 507)

A theoretical assumption by Selman that corresponds to this developmental sequence is that role-taking ability in an individual increases with age. Therefore, it can be assumed that role-taking ability is present in adults.

Adults (i.e., leaders and followers) are the focus of this research study; thus, Stage 4 was of particular interest to this investigator. Stage 4, as the last stage of Selman's theory of social cognition, represents the final and mature stage of perspective taking, which is the ultimate goal to be achieved by individuals. As individuals progress through each stage, it is anticipated that appropriate socialization will have occurred, culminating in the adult ability to role taking. However, according to Selman's theory, not all individuals will reach such an adult level of functioning (Muuss, 1982).

Measurement of Role Taking

Measurement of role taking has generally been limited to developmental studies dealing with children. Focus of the research has essentially looked at role taking as a skill that was developed during the numerous stages of cognitive and moral development (Keller, 1976; Sommers, 1984; Vikan, 1981). A majority of the role-taking measures that have been used require that a child responds to either verbal or audio stimuli (Feffer, 1959; Ianotti, 1985; Newman, 1986) or to a game in which the experimenter and child take turns hiding a coin (Ianotti, 1985). The responses from these measures were generally related to the accuracy of the children in describing the feelings portrayed in the stories or pictures or how well in predicting accurately where the coin was. Kurdek (1977) further studied the measurement of role taking to classify it as either an affective or cognitive skill.

Questions have been raised about the usefulness of these tools to measure role taking. First of all, researchers have determined that there is a serious problem concerning validity and reliability of these tests (Kurdek, 1977; Rubin, 1978). Second, these tools are geared toward children and have been used to study role taking as a developmental process only. They cannot adequately measure role-taking ability in adults. Because of the emphasis on children, there are very few measures

that can be used to investigate an adult's role-taking skills (Moser, 1984; Sommers, 1984). Third, these tests are concerned with predictive accuracy in role taking. Role-taking accuracy and role-taking ability do not refer to the same thing. Sherohman (1977) discussed the difference:

> Role taking accuracy is a situational, interpersonal construct. It refers to the extent to which one individual accurately imagines the plan of action (role) of another individual in a particular transaction. Role taking ability is a transsituational, psychological construct. It refers to the extent to which an individual possesses, as a psychological trait, a generalized ability to accurately imagine the roles of other people. (pp. 125-126)

The same research tools have been designed and used to measure both concepts, resulting in confusion between accuracy and ability. Role-taking accuracy implies role-taking ability, but role-taking ability does not imply role-taking accuracy.

Role-Taking Ability and Leadership

Research regarding role-taking ability and leadership is practically nonexistent. This is due to the lack of a measurement tool for use with adults and the developmental focus of measuring role-taking ability with children. Very few citations in the literature actually refer to role-taking ability as a leadership behavior. The topic is implied with terms such as "influencing, knowing,

identifying, and understanding."

A reference that does tie role taking to leadership is in the nursing education literature. Fagin and McGivern (1983) indicated that an individual who is able to use his or her "imagined model" (comparable to descriptions of role taking) will have greater potential for leadership than will an individual who needs continual validation.

In discussing the skills of an effective administrator, Katz (1974) identified three skills that are the basis for effective leadership: (a) technical skill, (b) human skill, and (c) conceptual skill. Katz stated that these skills are not necessarily present in an individual at birth but can be developed. These skills also must be evident in performance but are not necessarily evaluated in relation to their potential for use. This perspective supports the belief that behaviors that facilitate and augment leadership are acquired through a developmental process that can be achieved through practice.

Human skill, although not specifically identified by Katz (1974) as role taking, has all the integral characteristics of role taking. In his discussion of human skill, Katz stated:

> Human skill is the executive's ability to work effectively as a group member and to build cooperative effort within the team he [she] leads. This skill is demonstrated in the way the leader perceives (and recognizes the perceptions of) his [her] superiors, equals and subordinates, and in the way he [she] behaves subsequently. (p. 91)

Katz stated that the human skill must become an integral part of one's whole being and be consistently demonstrated to the followers:

> As a leader becomes adept at using human skill, he [or she] will be able to:
> (a) recognize the feelings, sentiments which he [she] brings to a situation,
> (b) have an attitude about his [her] own experiences which will enable him [her] to reevaluate and learn from them,
> (c) develop ability in understanding what others by their actions and words (explicit or implicit) are trying to communicate to him, and
> (d) develop ability in successfully communicating his [her] ideas and attitudes towards others. (p. 98)

A leader who demonstrates these behaviors creates an atmosphere of openness and freedom for expression of ideas without fear of unfavorable repercussion.

Organizations, Leadership, and Role Taking

Each organization has a way of influencing leadership through various organizational characteristics. Whatever the situation, the leader must consider how these characteristics affect the needs and demands of the organization, as well as the followers, to find ways of integrating them in a way that is both organizationally productive and individually fulfilling. In discussing

organizations, McNally (1986) stated that "organizational behavior almost universally involves multiple conflicting objectives, uncertainties, costs and benefits, . . . [and] there are no totally objective answers . . ." (p. 384).

The bureaucracies within an organization play a part in a discussion of leadership. The essence of bureaucracy is to standardize human behavior within the organization; thus, everything is done in a routine, formalized, and predictable way (Hoy & Miskel, 1987). Gibb (1974) stated that bureaucracies can significantly change the relations between a formal leader and his or her group.

> The leader of a large bureaucratic organization cannot be so representative in his [her] behavior as can the informal leader of a smaller primary group. His [Her] very position in the bureaucracy gives him [her] a different perspective, and of course, the longer he [she] occupies this office, the more different that perspective is likely to be, since he [she] has access to new kinds of knowledge and is subject to various extra-group pressures. (p. 240)

With the emerging professional orientation, nursing finds itself in conflict with a bureaucratic philosophy. A professional orientation, as summarized by Hoy and Miskel (1987), is characterized by:

> . . . technical competence acquired through long training; adherence to a set of professional norms that include a service ideal, objectivity, impersonality and impartiality; a colleague oriented reference group, autonomy in professional decision making; and self-imposed control based upon knowledge and standards. (p. 150)

To bridge the gap between the two orientations, bureaucratic versus professional, nursing education has employed a collegial approach. "Collegiality refers to an association of individuals bound together by a shared set of values and goals, bent on fostering mutual support and a common effort (Diers & Krauss, 1983, p. 197). Collegiality is an attitude that underlies how one conducts oneself as a professional; esteem for and trust in one's associates are its foundation (Mason & Talbott, 1985). The collegial approach also is appropriate to apply to the nursing practice setting.

With the collegial approach, there is the freedom of individuals to participate in the overall process of problem solving and decision making. According to Kohlberg (1969), decision making requires role taking.

The process of role taking is present in everyone, but not everyone develops the capacity to use this ability to the same degree. It is an important aspect of the leadership process. By using role taking, the leader can avail himself or herself of a wealth of information regarding the followers. This permits the leader to work with the group in an environment of trust, acceptance, and openness.

In summary, role taking is a developmentally acquired skill, originating from cognitive empathy. The ability to role take can facilitate both intrapersonal and

interpersonal relationships. Early research, conducted mainly with children, focused on role-taking accuracy as opposed to role-taking ability. Role taking is perceived to be a vital characteristic of leaders. Within the leadership process, role taking creates an environment in which there is a positive relationship, based on trust and openness, between leader and followers. In this type of environment, the leader will be perceived to provide effective leadership.

Leadership Effectiveness

Dimensions of Effective Leadership

More than 1,400 research studies have been conducted during the past century on the topic of leadership effectiveness (Munn, 1985). There is still little agreement on the means of identifying, describing, or evaluating such effectiveness. Stogdill (1974) stated, "The endless accumulation of empirical data has not produced an integrated understanding of leadership" (p. vii). Another researcher said, "Leadership is perhaps the most researched and least understood area of organizational behavior" (Sims, 1977, p. 133). As stated previously, effective leadership is defined as a judgment made regarding an individual's, group's, or organization's performance; the closer their actual performance is to the desired performance, the more effective those leaders are judged to be (Gibson et al., 1985).

The literature generally supports the belief that effective leadership is more dependent on how the leader handles the leadership role than on the personal attributes one possesses. Stogdill (1974) characterized effective leaders as those individuals who let subordinates know what is expected of them, informs subordinates of policy changes, explains reasons for decisions, and gets group reactions before carrying out new plans. Katz and Kahn, as quoted in Hollander (1978), described effective leaders as being able to:

> . . . clearly differentiate their role from the subordinate's role by not performing the subordinate's functions; they also spend time in supervision, but not clearly supervising subordinates minute by minute; and by expressing a concern for employees and their needs rather than being production oriented. (p. 113)

Fagin and McGivern (1983) pointed out that effective leaders understand power and use their power appropriately to influence. A classic statement of the distinction between power and influence was made by Bierstedt, as quoted in Hollander (1985), "Influence does not require power, and power may dispense with influence. Influence may convert a friend, but power coerces friend and foe alike" (p. 488). Burns (1978) suggested that to understand the nature of leadership, one must understand the nature of power, for leadership is a form of power. Most discussions of leadership and power begin with the basic premise that a leader is able to exert power over

others. This type of power relation has two features: (a) ability to exert power, in the sense of controlling others and events, and (b) the capacity to defend against power, or a type of counterpower (Hollander, 1985).

"A leader's perceived competence is an especially significant factor in leadership effectiveness" (Hollander, 1985, p. 492). Molony's (1979) description of effective leadership goes on to add that effective leadership is directly related to the leader's ability to behave in such a way that the leader is perceived by a majority of the group as conforming fairly close to group norms. From this perspective, effective leadership requires one to evaluate group norms and to be able to adapt behaviors to the expectations of specific groups. This is important since group norms differ from group to group. Tannenbaum and Schmidt (1958) maintained that a successful leader is one who accurately understands oneself, the individuals and group the leader is dealing with, and the company and broader social environment in which the leader operates. From this viewpoint, the leader provides effective leadership if he or she assesses the forces that determine what the most appropriate behavior should be and then actually behaves accordingly. McNally (1986) supported this perspective when she stated that effective leadership is contingent upon the leader's knowledge of human behavior. This knowledge is necessary

"to gain some understanding of human emotions, aggression, needs and the role of empathy in dealing with other human beings" (pp. 381-382).

Measurement of Leadership Effectiveness

Much of the measurement of leadership effectiveness has been based on productivity, cohesiveness, and satisfaction (Hollander, 1985). However, the concept of leadership effectiveness has been adapted to the specific context in which it has been used. This is due, in part, to no definite or conclusive definition. This also can be attributed to how leadership effectiveness has been evaluated, which has been dependent on the particular leadership theory or model one subscribes to. Even various definitions of leadership do not indicate much similarity. Stogdill (1974) pointed out that leadership has been viewed as various things, including a focus of group processes, a set of personality characteristics, the act of inducing compliance, the exercise of influence, an act or behavior, a form of persuasion, a power relation, an instrument of goal achievement, an effect of interaction, a differentiated role, and initiating structure. The following discussion presents a brief explanation of various approaches to leadership theory and their contribution to definitions and/or measurement of leadership effectiveness.

Early attempts to portray the essence of leadership focused on the personality characteristics or traits of successful leaders, influenced by the "great man" theory (Gibson et al., 1985; Hollander, 1985; Larsen, 1983; Sashkin & Lassey, 1983). This approach assumed that the individual achievements of great persons were the causal factors of effective leadership. Studies concentrated on what the leader was rather than what the leader did. Personality traits, social traits, and physical characteristics were suggested as ways of differentiating leaders from nonleaders. There was an assumption for a hereditary basis for leader qualities, placing leadership in a "survival-for-the-fittest" perspective. The trait approach to leadership did not produce any definitions of leadership effectiveness, nor did these studies produce any consistent findings to provide an acceptable understanding of leadership. There were considerable variations in the descriptions of effective leaders; thus, "any list of qualities that meant anything at all would be bound to exclude someone who had succeeded in leadership and include many who had failed," noted Jay, as quoted in Hollander (1985, p. 493).

Deficiencies of the trait approach to provide a foundation for the study of leadership led to a descriptive method focusing on leader behavior. This behavioral approach examined what leaders do when leading.

A significant assumption influencing this approach was that leadership behavior defines that individual's leadership effectiveness. At the University of Michigan a unidimensional approach was developed. A single-line continuum that ranged from employee-centered behavior to task-centered behavior was used (Gibson et al., 1985; Sashkin & Lassey, 1983). Three generalizations regarding leadership effectiveness surfaced as a result of field studies and experiments using this unidimensional behavioral approach. Hoy and Miskel (1987) listed them as:

1. More effective leaders tend to have relationships with their subordinates that are supportive and enhance their sense of self-esteem.
2. More effective leaders use group rather than person-to-person methods of supervision and decision making.
3. More effective leaders tend to set high performance goals. (p. 283)

Additional studies using the behavioral approach revealed that the unidimensional continuum was not adequate because the two behaviors identified on one continuum were two independent dimensions of leader behavior. The landmark development of the behavior approach was the program of research on leader behavior conducted at The Ohio State University. These researchers developed a rating scale for measuring leader behavior: Leadership Behavior Description Questionnaire (LBDQ). This LBDQ required subordinates to rate leaders on each of

nine behaviors. The two behaviors that accounted for the bulk of leader behavior were "initiation of structure" and "consideration" (Chemers, 1983; Hollander, 1985). Although previously defined, initiation of structure refers to "leadership behavior in delineating the relationship between the leader and members of the follower group, and in endeavoring to establish well-defined patterns of organization channels of communication and methods of procedure" (Halpin, 1957, p. 1). Consideration is representative of "leadership behavior that exemplifies friendship, trust, warmth, interest and respect in the relationship between the leader and members of the follower group" (Halpin, 1957, p. 1).

Considerable research has been conducted to examine and substantiate leader behavior using these two dimensions. Even though these two dimensions appeared to account for the bulk of leadership behavior, there was dissatisfaction with the limited perspective of leadership rendered by using only two dimensions to measure leadership. To expand the study of leadership, the LBDQ-XII was developed. This instrument added 10 subscales to the study of leadership behaviors. (See Instrumentation section in Chapter III for further discussion of the LBDQ-XII.)

The LBDQ-XII provided an expanded perspective for the study of leadership and laid the foundation for more in-

depth research into leadership behavior. Despite the fact that the study of leadership behavior was extended to 12 dimensions, the original 2, Initiating Structure and Showing Consideration, still remain the center of attention of leadership studies (Szilagyi & Keller, 1976). These 2 dimensions are still frequently the focus of analysis, either individually or in conjunction with other dimensions of the LBDQ-XII. The research studies of Herold (1974), Hoover (1984), Sheridan and Vredenburgh (1979), and Weed, Mitchell, and Moffitt (1976) are examples of studies using either the 2 main subscales of the LBDQ-XII or in conjunction with other subscales of the LBDQ-XII.

Generally speaking, research conducted on the relationship of these two factors to group productivity, satisfaction, and cohesiveness has been mainly positive (Hollander, 1985). Stogdill's (1974) summary of these results indicated 54 positive relationships, 18 zero relationships, and only 5 negative relationships. The most effective leaders tend to be associated with high scores on both scales (Hoy & Miskel, 1987; Sashkin & Lassey, 1983; Stogdill, 1974). According to Sashkin and Lassey, this two-dimensional behavioral approach represents the most widely used method of studying leadership theory, research, and training. The two behavioral dimensions of Initiating Structure and Showing

Consideration are observable and classify a considerable amount of actual behavior.

The situational approach also grew out of restlessness created by the obvious limitations of the trait approach (Hollander, 1985) and added another dimension to leadership--the environment.

> Situational theories stress the importance of discussing leadership as a function of (a) the personality characteristics of the leader, (b) the personality characteristics of the subordinates, (c) the performance expectations of the leader, (d) the performance requirements as perceived by the subordinates, and (e) the organizational climate in which the leader and his [her] subordinates function. (Ivancevich & Donnelly, 1970, p. 539)

Essentially the situational approach was an effort to define what was demanded of leaders in their situations. As occurred with the trait approach, the situational approach became exaggerated and failed to provide a view of processes of leader-follower relations over time (Hollander, 1985). Even though the situation approach had its own distinct failings, it prevailed and led the way to other developments in leadership theory.

Contingency models became an outgrowth of the situational approach as an attempt to specify the factors that make various leader qualities effective, given certain contingencies. These models emphasize conditions that call forth different leader attributes for effectiveness. The focus is on observed behavior. According to a contingency approach, leadership is a

dynamic process, varying from situation to situation with changes in followers, leaders, and situations (Pascarella & Lunenburg, 1988). Contingency models of leadership accept the assumption that no one style of leadership exists for all situations. Four contingency models are addressed: (a) Fiedler's Contingency Model of Leadership Effectiveness, (b) Vroom and Yetton's Decision-Making Model, (c) House's Path Goal Theory, and (d) Hersey and Blanchard's Situational Leadership Theory.

Fiedler's Contingency Model of Leadership Effectiveness is noted as the most prominent work of the contingency approach to leadership theory (Hollander, 1985). Fiedler's model proposed that the effectiveness of a task group or of an organization depends upon two main elements: (a) the personality of the leader and the degree to which the situation gives the leader control, power, and influence over the situation; or, conversely, (b) the degree to which the situation confronts the leader with uncertainty (Fiedler, 1983).

The Fiedler model is built around the leader's style, distinguishing between leaders who are relationship oriented and those who are task oriented (Hollander, 1985; Sashkin & Lassey, 1983). Contingency factors or situational variables that influence leadership effectiveness, rated from highest importance to lowest importance, are as follows: (a) leader-member relations,

referring to the amount of confidence and loyalty followers have in their leader; (b) task structure, relating to the number of correct solutions to a situation; and (c) leader position power, which is dependent upon the amount of organizational support available to the leader (Hollander, 1985; Hoy & Miskel, 1987; Marriner, 1986; Sashkin & Lassey, 1983). By evaluating and plotting each of these variables on a grid, the leader is able to ascertain what leadership style would be most appropriate for a certain situation. According to Fiedler, leader effectiveness is defined by how well the group is able to accomplish its primary task in relation to the structural variables (Hoy & Miskel, 1987).

Fiedler's model is able to predict, although not perfectly, which leaders will be effective in various situations, even though reasons for the model's accuracy have never been explained (Sashkin & Lassey, 1983). There are numerous criticisms regarding the Fiedler model, some referring to validity and reliability measures (Rice & Kastenbaum, 1983; Strube & Garcia, 1983; Vecchio, 1983; Wofford, 1985). However, Fiedler's model has played a significant role in the study of leadership by pointing out the complexities of the leadership process (Gibson et al., 1985).

The Vroom and Yetton Decision-Making Model is a

contingency model that is specifically concerned with leader styles in the process of decision making in organizations. This model provides a means to diagnose situations in determining the most appropriate problem-solving technique. This model integrates three situational variables of quality, acceptance, and time, suggesting a decision-making style that has the highest probability for leadership effectiveness (LaMonica, 1990). This model is referred to as a "normative model of decision making," i.e., emphasizing what is appropriate (Hollander, 1985). Both the Vroom and Yetton model and the Fiedler model are leader centered; however, the Vroom and Yetton model is more attentive to follower acceptance of decisions.

The Path Goal Model, developed by House (1971), provides for an analysis of the leader's behavior as a basis for increased follower motivation. Contingency factors involved in this model are associated with required leader behavior. These are (a) the task, (b) the nature of the subordinates, and (c) the nature of the group in which the subordinates work (Hollander, 1985). Leader behavior, represented by initiating structure and showing consideration, influences follower perceptions of "path-goal instrumentality," which is the extent to which a given path is seen to help or hinder the individual in accomplishing his or her goal. Rewards for the

accomplishment of goals play a strategic part in this theory; thus, the leader should be adaptable and choose a leadership style that will assist the follower toward goal accomplishment (Gibson et al., 1985; Marriner, 1986).

Leadership effectiveness is defined in a limited scope in the Path Goal Model. Leader behavior is effective to the extent that it "improves subordinate job satisfaction, enhances the acceptance of the leader and increases subordinate motivation" (Hoy & Miskel, 1987, p. 294). There are still questions concerning the useful predictive ability of the model, as very few hypotheses have been generated from the model's usage, and there have been inconsistent research results (Gibson et al., 1985).

Hersey and Blanchard's Model of Contingency Leadership focuses on the maturity of followers as the contingent variable for task or relationship behavior. This theory is based on the amount of direction (i.e., task-directive behavior) and the socioemotional support (i.e., relationship behavior) a leader must provide given the situation and the level of maturity of the followers or group regarding a specific task (Pascarella & Lunenburg, 1988).

In summary, the leader-follower relationship is the basis for leadership effectiveness. Definitions of leadership effectiveness are determined according to the particular leadership theory and/or model one subscribes

to. Trait theories failed to provide satisfactory analysis of leadership behavior. The behavioral approaches created a two-dimensional model, which is, at the present time, the most widely accepted and used approach to leadership theory and research. Situational approaches to leadership theory introduced the environment as a contributing factor to leadership effectiveness. Contingency models specified the factors that contribute to leadership effectiveness, given certain contingencies.

Conclusion

In conclusion, based upon the review of the literature related to empathy, role taking, and leadership effectiveness, the value of conducting a controlled study of role taking as a determinant of leadership effectiveness is indicated. Empathy has been shown to augment effective leadership and to develop learning empathic skills, or role taking, through leadership development, can lead to greater success as a leader (Bass, 1981). It is only through the understanding of effective leadership behavior that one can identify characteristics of leaders that will be significant to those who aspire to become effective nursing leaders within a hospital setting.

CHAPTER III

METHODOLOGY

This chapter outlines the methods used to investigate the relationship between role-taking abilities of head nurses and their perceived leadership effectiveness. A description of the design, sample, procedures, instrumentation, and statistical data analysis is presented.

Design

A survey research design was used. Questionnaires were utilized to obtain data from two groups: (a) head nurses and (b) staff nurses who report to the head nurses in the study. Statistical techniques of correlation and regression were used to examine the relationship between head nurses' role-taking abilities and staff nurses' role-taking abilities and their ratings of their head nurses' leadership effectiveness.

Sample

The type of sampling utilized for this study employed a nonprobability technique of convenience sampling. This type of sampling allows for use of the available group of research subjects (Wilson, 1985). The sample for this

study consisted of head nurses from two Salt Lake City area hospitals and members of their staff nurses. These two hospitals were chosen because they are both tertiary hospitals, teaching consortiums, and affiliated with the University of Utah. Head Nurse Councils from both hospitals expressed an interest in participating in this research study prior to beginning data collection.

A minimum number of four staff nurses is needed to obtain valid results on the LBDQ-XII to evaluate the relationship between the head nurse and staff nurse. All staff nurses of each respective head nurse, in attendance at the data collection meeting, were given the opportunity to volunteer to participate in the study.

Procedures

The data collection process involved the following steps.

Ethical Consideration

This study was subject to review and approval by the Review Committee for Research with Human Subjects of the Institutional Review Board for the University of Utah. In addition, various committees at the institutional level subjected this investigation to review and approval. All possible efforts to ensure confidentiality of the subjects were made.

Consent and Protection of Subjects' Rights

Questionnaire packets contained a cover letter signifying that consent to participate in the study was given upon completing and returning the questionnaires (see Appendix A for the head nurse and Appendix B for the staff nurse). Participation was voluntary, and subjects were informed as to how the data would be used, what the risks would be for participation, and how the rights of the subjects would be protected. Questionnaires were coded to match up the head nurses with their staff nurses. Coding was necessary for data entry for statistical analysis as well as to evaluate that a minimum number of four staff nurses per unit participated. Responses were kept confidential. No individual subject or nursing unit could be identified as all information was reported in statistical aggregates. In the cover letter, subjects were asked to keep the letter for future reference regarding their rights and the rights and responsibilities of the investigator.

Data Collection

Each head nurse was contacted by the investigator to explain the study and to outline what his or her participation would be if he or she chose to participate. Confidentiality for participating on the part of the head nurses was maintained, but anonymity could not be

provided. Only those staff nurses whose head nurse had participated were eligible to participate. A time was arranged with the head nurse for the investigator to attend a regularly scheduled staff meeting for data collection. If a staff meeting was not available for the investigator to attend, a time was arranged with the head nurse to meet with the staff nurses at shift change. At this time, each staff nurse in attendance was given the opportunity to volunteer to participate. Both groups completed their questionnaires at this time. Each group received a cover letter outlining consent procedures and questionnaires. The questionnaires for the head nurses consisted of a Demographic Questionnaire: Head Nurse and the IRI for information on role-taking ability. Three questionnaires were provided for the staff nurse, consisting of a Demographic Questionnaire: Staff Nurse, the IRI to obtain information on role-taking ability, and the LBDQ-XII for a rating of leadership behavior exhibited by their head nurse.

Confidentiality and anonymity were maintained for the staff nurse because neither the head nurse nor the investigator had knowledge as to which staff nurses participated. The head nurse and the investigator left the room when the staff nurses were given the opportunity to participate. A designated staff nurse collected the questionnaires (whether completed or not) and returned

them to the investigator. At this time the head nurse completed his or her questionnaires.

Instrumentation

Instruments included in the questionnaire packet were the (a) Demographic Questionnaire: Head Nurse (see Appendix C) and Demographic Questionnaire: Staff Nurse (see Appendix D), (b) IRI (see Appendix E), and (c) LBDQ-XII (see Appendix F). Head nurses were asked to complete the Demographic Questionnaire: Head Nurse and the IRI. Staff nurses were asked to fill out the Demographic Questionnaire: Staff Nurse, IRI, and LBDQ-XII. A description of each questionnaire follows.

Demographic Questionnaires

The Demographic Questionnaire: Head Nurse and Demographic Questionnaire: Staff Nurse asked for responses to questions regarding the subject's background characteristics. These consisted of gender, length of time in nursing, educational level, degree of professional activity, interaction time between head nurse and staff nurse, organizational characteristics (formalization and centralization), and job satisfaction. Information obtained from both the Demographic Questionnaire: Head Nurse and Demographic Questionnaire: Staff Nurse was used to describe the subjects, to control for confounding variables, and to test the research hypotheses.

Gender, length of time in nursing, and educational level were categories that Mansen (1988) used for his demographic questionnaire evaluating the area of nursing education.

The degree of professional activity was included as a criterion based on a study by Hoover (1984) who looked at job satisfaction of staff nurses based on head nurses' leadership effectiveness. Degree of professional activity was related to staff nurse job satisfaction, but not significantly. Although Hoover's study had a different focus, it used the same instrument (i.e., LBDQ-XII) for measuring leadership effectiveness as was used in this study. It was believed by this investigator that it was worth exploring to evaluate if a correlation could be found.

Mansen (1988) recommended that in replicating his study, "It would also be of benefit to be able to examine the overall relationship that exists between dean/department chairperson [head nurse] and the faculty [staff nurse]" (p. 141). For this reason, the question regarding interaction time between head nurse and staff nurse was included.

The organizational characteristics of formalization and centralization are identical to Mansen's (1988) study. Respondents were asked to rank the nursing unit using a Likert scale on a continuum from <u>high</u> (5) to <u>low</u> (1)

(Grigsby, 1988). Definitions for these terms are specified; thus, respondents could interpret the concepts consistently.

Information on job satisfaction was obtained by having the respondent rank, using a Likert scale, how well he or she liked working for the particular institution. This ranking was identical to that used by Mansen (1988). The job satisfaction question was taken from the Job Satisfaction Inventory (Kahn et al., 1964). This question did not consider all the variables that make up job satisfaction but was used to obtain some information on the degree of general job satisfaction derived from that particular institution.

Demographic Questionnaire: Staff Nurse. In addition to the above, the Demographic Questionnaire: Staff Nurse included two questions regarding the shift the staff nurse usually worked. They were included to clarify the response the staff nurse would make to the question regarding interaction time between head nurse and staff nurse.

Demographic Questionnaire: Head Nurse. This questionnaire also requested information regarding the shift the head nurse predominantly worked, as well as if the head nurse ever worked as staff providing patient care. These questions were included to clarify the question regarding interaction time between head nurse and

staff nurse. The Demographic Questionnaire: Head Nurse also elicited information regarding bed size of nursing unit and number of type of staff. This was added, based on a recommendation by Mansen (1988) for replication, to include more information on the differences in size of groups that may represent differing perspectives on the leadership activities. Information was requested from the head nurse regarding the type of nursing unit, i.e., psychiatric unit vs. intensive care unit. Information regarding length of time as a supervisor, as well as length of time as supervisor of that particular unit, was requested.

Interpersonal Reactivity Index

The IRI was developed by Davis (1980) to measure the cognitive and affective dimensions of empathy. Other instruments used to measure empathy produce a single score (Mehrabian and Epstein's [1972] Emotional Empathy Scale, and Hogan's Empathy Scale [1969]), not incorporating the multidimensional aspects of empathy or individual difference measures of empathy. The IRI was designed to capture separate individual variations in cognitive, perspective-taking tendencies of respondents as well as differences in the types of emotional reactions (Davis, 1980). Davis developed the IRI with four separate subscales, each measuring an individual construct of empathy. These constructs, along with their definitions,

are:

> 1) Perspective Taking--Reflects an ability to shift perspectives or to step "outside the self" when dealing with other people. The items comprising this scale refer to "real life" instances of perspective taking (role taking).
> 2) Fantasy--Taps the tendency to imaginatively transpose oneself into fictional situations (i.e., movies, books, daydreams).
> 3) Empathic Concern--Assesses the degree to which the subject experiences feelings of compassion, warmth, and concern for the observed individual. This deals with individual differences in emotional responses to observed emotionality in others.
> 4) Personal Distress--Measures the individual's own feelings of fear, discomfort, and apprehension at witnessing the negative experiences of others. (p. 85)

The IRI was developed utilizing more than 50 items. Some of these items were adapted or borrowed from other measures (i.e., emotional/empathy scale [Mehrabian & Epstein, 1972] and Fantasy/Empathy scale [Stotland, 1969]); however, the majority was written for the new instrument. This first version was administered to 201 males and 251 females. These individuals responded to the items using a 5-point scale ranging from 0 (<u>does not describe me well</u>) to 4 (<u>describes me very well</u>). Factor analysis (Joreskog factor analysis, oblique rotation, and delta = 0) revealed four groupings that corresponded to the four subscales.

The second version consisted of 45 items, constructed from items taken intact from the preliminary IRI, items adapted from that questionnaire, and some new items written to conform to one of the four empathy subscales

(Davis, 1980). Subjects responded using the same 5-point scale as the first version. This version was administered to 221 males and 206 females. Separate factor analyses (Joreskog factor analysis, oblique rotation, and delta = 0) were conducted on the data collected from respondents to determine if the factor structure established from the earlier analyses would emerge from the responses of the new questionnaire. The factors emerging from these analyses were nearly identical in both sexes. The same four subscale groupings emerged: (a) Perspective Taking, (b) Fantasy, (c) Empathic Concern, and (d) Personal Distress.

The final item selection was based on those items that loaded most heavily, in both sexes, on their respective factors. This resulted in a 28-item instrument, consisting of four discrete, 7-item subscales. The standardized alpha coefficients for each subscale were as follows: (a) Perspective Taking--males = .71, females = .75; (b) Fantasy--males = .78, females = .79; (c) Empathic Concern--males = .68, females = .73; and (d) Personal Distress--males = .77, females = .75.

To confirm the final empathy questionnaire, the new 28-item instrument was administered to a third, independent set of subjects. The same 5-point scale was used. This scale was administered to 579 males and 582 females. Factor analyses (i.e., Joreskog factor analysis,

oblique rotation, and delta = 0) provided strong support for the use of the four empathy subscales. The standardized alpha coefficients were similar to those specified previously. The results of the factor analyses and the standardized alpha coefficients provided convincing evidence for Davis (1980) that an internally reliable set of subscales had been developed.

Test-retest reliabilities were conducted. An independent sample (i.e., 56 males and 53 females) completed the questionnaire twice. The period of time between the administration of the first and second questionnaire ranged from 60 to 75 days. For the male subjects, correlations between the test and retest scores ranged from .61 to .79, and for females the range was from .62 to .81. This demonstrated temporal stability for this instrument.

Davis (1980) pointed out that significant differences between males and females were determined for each of the four subscales. Mean scores for each of the subscales were as follows: (a) Perspective Taking--males = 16.78, females = 17.96; (b) Fantasy--males = 15.73, females = 18.75; (c) Empathic Concern--males = 19.04, females = 21.67; and (d) Personal Distress--males = 9.46, females = 12.28. Females scored higher than males for each subscale. This finding is consistent with previous research showing that females exhibit higher empathy

scores (Becker & Sands, 1988; Davis & Oathout, 1987; Dymond, 1949; Mehrabian & Epstein, 1972).

Scoring of the IRI is based upon a 5-point scale ranging from 0 (does not describe me well) to 4 (describes me very well). Each item can yield a maximum score of 4. Scores on each of the subscales can range from 0 to 28. These figures can be interpreted as an index of the individual's capacity for empathy for each of the four subscales.

For purposes of this study, two subscales of the IRI were used: (a) Perspective Taking and (b) Fantasy. Utilizing only one or more subscales of this instrument is appropriate since each subscale has been identified as a discrete and independent measure of the empathic ability of the individual (Davis, 1980) and has been conducted in other studies (Davis, 1983; Davis & Oathout, 1987). The Perspective Taking scale was chosen for this study because it directly relates to role-taking ability as well as cognitive empathy. "The correlation between PT [perspective taking] . . . and the Hogan is consistent with conclusions drawn from the literature defining the scale as one that measures role-taking ability" (Chlopan et al., 1985, p. 651). Items from the Fantasy scale were included in the questionnaire for this study to buffer the effects of the seven primary questions of Perspective Taking. The Fantasy scale also was chosen because it and

the Perspective Taking scale constitute the cognitive component of empathy.

Leadership Behavior Description Questionnaire-XII

The LBDQ-XII is a revision of the original LBDQ. The original LBDQ was developed by Hemphill and Coons in the late 1940s and early 1950s at The Ohio State University. It was developed as an interdisciplinary venture of psychologists, sociologists, and economists in order to create a tool for measuring how leaders carry out their activities (Hemphill & Coons, 1957). Initially, nine dimensions of leader behavior consisting of 1,790 items were considered that resulted in a 130-item questionnaire. Factor analysis of initial test results from U.S. Air Force bomber crews revealed four factors that described leadership behaviors. Factors that accounted for the bulk of leader behavior were Initiating Structure and Showing Consideration, which accounted for 83% of the variance (Dipboye, 1978).

Initiating Structure and Showing Consideration have been identified by Lake, Miles, and Earle (1973) to reflect task and socioemotional leader behavior, respectively. Initiating Structure can be defined as "the extent to which a leader initiated activity in the group, organized it, and defined the way work was to be done" (Bass, 1981, p. 359). This includes leader behavior such

as getting subordinates to follow rules and procedures, maintaining standards of performance, and delineating leader and subordinate roles (Hollander, 1985). Consideration is defined as "the extent to which a leader exhibited concern for the welfare of the other members of the group" (Bass, 1981, p. 358). This includes such leader behavior as looking out for the welfare of subordinates, helping them, explaining things, being available, and being friendly (Hollander, 1985).

The final version of the LBDQ consisted of 40 items, 15 addressing Initiating Structure, 15 pertaining to Showing Consideration, and 10 used as buffer questions that are not scored. Each dimension is scored by adding the 15 items pertaining to that dimension. The scores range from 0 to 60 for each dimension, with each item ranging from 0 to 4. Leadership scores are the averages of the subordinate's scores. The estimated reliability by the split-half method is .83 for the Initiating Structure scores and .92 for the Showing Consideration scores, when corrected for attenuation. For two studies, the intercorrelations between the two dimensions have been reported to be .45 ($p < .01$) and .38 (Lake et al., 1973). The scale intercorrelations signify that these two dimensions are not independent (Bass, 1981; Dipboye, 1978; Lake et al., 1973). No test-retest reliability has been established for the LBDQ (Schriesheim & Kerr, 1974).

The LBDQ has face validity in that it appears to measure the appropriate constructs. The straightforward items match common-sense descriptions of leader behavior in a variety of settings. There is evidence that the LBDQ has construct validity. Halpin, as identified in Hollander (1985), found that air crews scoring high on effectiveness had leaders with high scores on both Initiating Structure and Showing Consideration. In contrast, crews with the lowest overall effectiveness had leaders with low scores for both dimensions.

A serious defect of the LBDQ is a confounding of authoritarian and punitive leadership with the Initiating Structure scale (Dipboye, 1978). A limitation of the LBDQ is that it only measures two dimensions of leadership. However, in the majority of cases, these two dimensions describe and encompass the substance of leadership.

In order to understand the complexities of leadership behavior, the LBDQ-XII was developed to include what was believed to be missing information from the LBDQ. Ten additional conceptually independent subscales were identified, developed, and added to the two subscales (i.e., Initiating Structure and Showing Consideration) of the LBDQ. These additional subscales and their definitions follows:

1. Representation - speaks and acts as the representative of the group.
2. Demand Reconciliation - reconciles conflicting demands and reduces disorder to system.
3. Tolerance of Uncertainty - is able to tolerate uncertainty and postponement without anxiety or upset.
4. Persuasiveness - uses persuasion and argument effectively; exhibits strong convictions.
5. Tolerance of Freedom - allows followers' scope for initiative, decision [making], and action.
6. Role Assumption - actively exercises the leadership role rather than surrendering leadership to others.
7. Production Emphasis - applies pressure for productive output.
8. Predictive Accuracy - exhibits foresight and ability to predict outcomes accurately.
9. Integration - maintains a closely knit organization; resolves intermember conflicts.
10. Superior Orientation - maintains cordial relations with superiors; has influence with them; is striving for higher status. (Stogdill, 1963, p. 3)

The LBDQ-XII consists of 100 items. The subscales contain either 5 or 10 items. Both the Initiating Structure and Showing Consideration scales contain 10 items. Scoring is done for each item on a 0 to 4 scale. Subjects are asked to describe the frequency of demonstrated leader behavior by circling the letter of the alphabet that corresponds appropriately. The responses are given as follows: (a) A = always, (b) B = often, (c) C = occasionally, (d) D = seldom, and (e) E = never. Twenty of the items are scored negatively, with A corresponding to 0; the additional 80 items are scored with A corresponding to 4. The Showing Consideration

scale was written with reversed items; the Initiating Structure scale was not (Schriesheim & Kerr, 1974). Each subscale is scored by summing the scores assigned to the items of that subscale.

The LBDQ-XII has been found to possess internal consistency, interrater reliability, and test-retest reliability of several of the scales (Dipboye, 1978). The internal consistency coefficients range from .38 to .91 (Stogdill, 1963), with the majority of these coefficients in the .70s and .80s. This demonstrates reasonably good internal consistency. The Showing Consideration scale had reliability coefficients of .76 to .87, and the Initiating Structure scale's reliability coefficients were .72 to .80. Evidence exists to support concurrent validity of the LBDQ-XII; its scales correlate with the external criteria of performance and job satisfaction, as well as being capable of distinguishing between persons displaying behaviors corresponding to the dimensions of this tool (Dipboye, 1978). Experimental validity (i.e., differential validity) was shown by Stogdill (1969) by using scenarios for actors to depict different leader behaviors and observers to rate the role using the subscales of the LBDQ-XII. Under these conditions, the scales measured what they claimed to measure. The LBDQ-XII has been found to be more content valid than the LBDQ due to the elimination of items pertaining to

authoritarian and punitive leadership (Dipboye, 1978). Schriesheim and Kerr (1974) determined that content validity is only marginally acceptable. However, the popularity of this instrument supports its continued use in research. There are no reports of studies to support construct validity or predictive validity for the LBDQ-XII (Schriesheim & Kerr, 1974).

Factors that influence results from the LBDQ are response attributes related to halo effects, social desirability and leniency, and agreement response tendencies. Halo effects refer to an observer's (i.e., subordinate's) tendency to rate particular subjects (i.e., leader) as consistently high or low on all details due to an overall impression the subject gives the rater (Wilson, 1985). Bass (1981) found that this generally occurs when ambiguity is associated with the items that are being rated regarding leader behavior. The halo effect decreases as the ambiguity decreases and as one is asked to describe a specific leader.

Social desirability is the tendency to describe oneself in socially desirable terms (Schriesheim & Kerr, 1974). Leniency is found when descriptions of the leader who is liked possesses socially desirable traits as opposed to possessing undesirable traits. Schriesheim, Kinicki, and Schriesheim, as identified in Hollander (1985), defined leniency as a tendency to describe others

in favorable but probably untrue terms. They determined that leniency affects the Showing Consideration scale more than the Initiating Structure scale.

Agreement response tendencies occur when raters cluster their responses; thus, there is minimal variance. This factor can be controlled for by writing reversed items (Schriesheim & Kerr, 1974). This was done for the Showing Consideration scale but not for the Initiating Structure scale.

As is always the case when using a Likert scale, the interval equivalency is subject to concern. Both the LBDQ and the LBDQ-XII failed to distinguish the measurement of frequency of leader behavior with the magnitude of leader behavior. This is also a problem with other scales developed by The Ohio State University leadership group. There is, however, consistency among the responses since both tools measure only frequency of behavior, even if equality does not exist.

For purposes of this study, only two of the subscales of the LBDQ-XII were used: Initiating Structure and Showing Consideration. There was no explicit definition of leadership effectiveness, even if one uses all 12 of the subscales. For this study, leadership effectiveness was determined and measured by scores on these two dimensions. Utilizing these two subscales is appropriate for a study of leadership since they are a major focus for

leadership research. Using only one or more subscales from the LBDQ-XII is appropriate and has been done when a specific premise or behavior was the primary focus of research (Herold, 1974; Hoover, 1984; Sheridan & Vredenburgh, 1979; Weed et al., 1976).

The LBDQ-XII was chosen primarily over the LBDQ because of the decreased emphasis on autocratic and punitive behaviors in the Initiating Structure subscale of the LBDQ-XII. When the LBDQ-XII was revised from the LBDQ, some questions pertaining to autocratic and punitive leader behavior were removed. In addition, the LBDQ-XII was designed to measure actual leader behavior, as opposed to descriptions of leader behavior related to the LBDQ.

Correlations of the two subscales and explanations of their relationship to each other were examined. Lowin, Hrapchak, and Kavanaugh (1969) investigated the relationship between Initiating Structure and Showing Consideration and found one concept existing in both scales that contributed to the intercorrelation of the two scales. This is the concept of participative decision making. Its presence contributes to high consideration and low initiating structure. Lowin et al. stated, "This is intuitively sensible, for allowing subordinates to participate in decision making implies a concern for their opinions and for their desire to contribute [high consideration] and a relaxation of hierarchical control

[low structure]" (p. 252). This is the type of environment that is crucial to a professional bureaucracy, characteristic of what an ideal nursing unit environment would be.

Two subscales of the LBDQ-XII were used in this study: Initiating Structure and Showing Consideration. This is an abridged form of the LBDQ-XII consisting of 20 questions, 10 for each dimension. Scoring of the questionnaire is determined by the responses to each item within the dimension related to the frequency of demonstrated behaviors by the head nurse. The range of scores on each of the items extends from 0 (never) to 4 (always). This results in a range of 0 to 40 for a final score for each dimension. The leader is assigned one set of scores in each dimension. These are obtained from the staff nurse's scores; that score is the average of the scores obtained from each staff nurse from a particular nursing unit relative to the ratings of the items from each dimension.

Data Analysis

Pearson product-moment correlations were calculated to examine the relationship between role-taking ability and leadership effectiveness. Data obtained from the IRI and LBDQ-XII were treated as interval data, thus making the Pearson product-moment correlation coefficient appropriate. Partial correlations were conducted to

control for the effects of role-taking abilities of the staff nurse when analyzing the staff nurse's rating of the head nurse's leadership effectiveness.

Summary

Methods used for this study have been presented. The research design and sample selection have been outlined. Procedures for data collection included the ethical considerations, consent, and methods of protection of subject's rights. Instrumentation for this study and the data analysis plans have been presented and discussed. This methodology chapter, combined with the two preceding chapters, has laid the foundation for presenting the data in the following chapters.

CHAPTER IV

PRESENTATION, ANALYSIS, AND INTERPRETATION OF THE DATA

The purpose of this chapter is to present the results of data collection and provide an analysis of that data. This chapter is organized to present descriptions of the sample, reliability inventories, and data analysis as they pertain to the research hypotheses.

Description of Sample

The description of the sample consists of three sections: (a) a summary of the total sample, (b) a summary of the head nurses, and (c) a summary of the staff nurses. Specific information associated with each of these groups is presented in Table 1 outlining the pertinent descriptive statistics.

Description of Total Sample

The total sample consisted of 202 individuals who participated in this study; there were 19 head nurses and 183 staff nurses. All individuals were from two Salt Lake City area hospitals (hereafter referred to as Hospital A and Hospital B). Of the total sample in this study, 55.9% were from Hospital A, and 44.1% were from Hospital B.

Table 1

Demographic Data of Sample

Variables	Sample		
	Head nurses (n = 19)	Staff nurses (n = 183)	Total group (N = 202)
Gender			
Male	1 (5.3%)	22 (12.2%)[a]	23 (11.6%)
Female	18 (94.7%)	158 (87.8%)[a]	176 (88.4%)
Length of time in nursing			
0-1 years		12 (6.7%)[b]	12 (6.0%)
2-3 years		25 (13.9%)[b]	25 (12.6%)
4-5 years	1 (5.3%)	24 (13.3%)[b]	25 (12.6%)
6-7 years	3 (15.8%)	18 (10.0%)[b]	21 (10.5%)
8+ years	15 (78.9%)	101 (56.1%)[b]	116 (58.3%)
Highest degree of education			
LPN		23 (12.8%)[c]	23 (11.6%)
RN (diploma)		19 (10.6%)[c]	19 (9.6%)
RN (ADN)	1 (5.3%)	44 (24.6%)[c]	45 (22.7%)
RN (BSN)	11 (57.9%)	86 (48.0%)[c]	97 (49.0%)
RN (MS)	7 (36.8%)	7 (3.9%)[c]	14 (7.1%)
Member of professional nursing organization			
Yes	15 (78.9%)	82 (45.8%)[d]	97 (49.0%)
No	4 (21.1%)	97 (54.2%)[d]	101 (51.0%)
Of those responding yes to above, number of memberships to nursing organizations			
One organization	7 (46.7%)	60 (74.1%)[e]	67 (69.8%)
Two organizations	8 (53.4%)	21 (25.9%)[e]	29 (30.2%)
Formalization (1 [low] to 5 [high])			
Mean	3.42	3.69	
SD	1.02	.99	

Table 1 (Continued)

Variables	Sample: Head nurses (n = 19)	Sample: Staff nurses (n = 183)	Sample: Total group (N = 202)
Centralization (1 [low] to 5 [high])			
Mean	3.42		3.30
SD	1.12		1.16
Job Satisfaction (1 [low] to 5 [high])			
Mean	3.95		3.79
SD	.23		.65

[a]Three missing observations.

[b]Three missing observations.

[c]Four missing observations.

[d]Four missing observations.

[e]One missing observation.

A large majority of the study participants was female, totalling 88.4%; males accounted for 11.6% of the sample. A majority of the study participants (58.3%) had practiced nursing for 8 years or more. The most prominent level of nursing education was at the baccalaureate level with a BSN degree, accounting for 49% of the total study sample. A higher percentage of head nurses (78.9%) were members of a professional nursing organization, as compared with staff nurses (45.8%); however, approximately half of the total population (49.0%) were members of a professional nursing organization.

Head nurses were asked to classify the type of their nursing unit to determine what fields of nursing the study participants came from. Up to two classifications were allowed to describe the type of nursing practice (i.e., medical and intensive care unit [ICU] may have been checked to signify a medical ICU). Six of the 19 units used two classification codes. Table 2 shows the multiple-response cross-tabulation of this information. Approximately one-third (31.6%) of the units had medical patients, and approximately one-fifth (21.1%) of the units had surgical patients. ICUs accounted for 15.8%, and the Operating Room units accounted for 10.5%.

The size of the unit, based on number of patient beds, also was provided by the head nurse. One-third of the study participants worked on units with 31 to 40

Table 2

Type of Nursing Unit: Multiple-Response Cross-Tabulation

Unit/type	Total
ICU	
Number	3
Percent	15.8
Medical	
Number	6
Percent	31.6
Surgical	
Number	4
Percent	21.1
Obstetrics	
Number	1
Percent	5.3
Pediatrics	
Number	1
Percent	5.3
Psychiatric	
Number	1
Percent	5.3
Neurology	
Number	1
Percent	5.3
Operating Room	
Number	2
Percent	10.5
Emergency Room	
Number	1
Percent	5.3
Other	
Number	5
Percent	26.3

Note. This table represents more than one response (up to a total of two responses) for some subjects, but serves to provide a general understanding of the areas of nursing represented.

patient beds. This information is detailed in Table 3.

Description of Head Nurses

Of the 19 head nurses who participated in this study, 42.1% were from Hospital A, and 57.9% were from Hospital B. All but 1 head nurse was female. Greater than half (57.9%) had their BSN degree, and more than one-third (36.8%) had a MS degree; only 5.3% had an ADN degree.

No head nurse had practiced in nursing for less than 4 years; the majority (78.9%) of head nurses had been in nursing for 8 years or more. Nearly one-third (31.6%) of the head nurses had been supervisor of their unit for approximately 1 year. Roughly one-fourth (26.3) had been supervisor of their unit for 4 to 5 years (see Table 4). Supervision time, in addition to their current unit, also is depicted in Table 4.

Sixteen of the 19 head nurses (84.2%) worked an 8-hour day shift; the other 3 (15.8%) worked a 12-hour day shift. When asked if the head nurse worked as staff by providing patient care, 73.7% responded that they did; 26.3% did not. Of those who said yes, 50% provided patient care two to three times per week; and 28.6% responded that they did so once per week. All head nurses (100%) in the study maintained that they interacted with their staff nurses every day.

Greater than three-fourths (78.9%) of the head nurses were members of a professional nursing organization, 21.1%

Table 3

Bed Size of Nursing Unit

Bed size	Total
1 to 10	
Number	4
Percent	22.2
11 to 20	
Number	5
Percent	27.8
21 to 30	
Number	3
Percent	16.7
31 to 40	
Number	6
Percent	33.3
Total	
Number	18
Percent	100.0

Note. Number of missing observations = 1.

Table 4

Length of Time in Supervision of Head Nurses: Current Unit and Other Units

	Current units	Other units
0 to 1		
Number	6	6
Percent	31.6	31.6
2 to 3		
Number	4	4
Percent	21.1	21.1
4 to 5		
Number	5	3
Percent	26.3	15.8
6 to 7		
Number	1	2
Percent	5.3	10.5
8+		
Number	3	4
Percent	15.8	21.1
Total		
Number	19	19
Percent	100.0	100.0

were not. Of those who had membership with professional nursing organizations, 46.7% belonged to one organization; 53.4% belonged to two or more professional nursing organizations. The degree of professional involvement is presented by a multiple-response cross-tabulation (see Table 5). Study participants were asked to circle all responses that applied to them. Most participants (94.7%) read publications of professional nursing organizations or attended educational offerings or conventions (84.2%).

"Formalization," defined as the degree that rules are used by the organization to ensure continuity and consistency (Grigsby, 1988), was rated on a Likert scale. A score of 1 represented low formalization, i.e., where rules were used to determine decisions only when necessary and when the nursing unit operated with few written rules and procedures. Five represented high formalization, i.e., when rules were used to guide almost all decisions and when the nursing unit operated using clearly specified rules and procedure manuals. The mean score for the head nurses was 3.42 (see Table 6).

"Centralization," defined as administrative authority to make decisions about the people (Grigsby, 1988), was rated on a Likert scale. A score of 1 represented low centralization, i.e., where administrative authority is shared among many people. Five represented high centralization, i.e., where administrative authority is

Table 5

Degree of Professional Involvement of Head Nurses and Staff Nurses: Multiple-Response Cross-Tabulation

	Number	Percent
Head nurses		
Read publications	18	94.7
Participate in organizational functions	10	52.6
Attend education offerings or conventions	16	84.2
Committee member	4	21.1
Hold elected position	3	15.8
Staff nurses		
No involvement	35	20.8
Read publications	97	57.7
Participate in organizational functions	38	22.6
Attend education offerings or conventions	96	57.1
Committee member	22	13.1
Hold elected position	9	5.4

Note. This table represents more than one response (up to a total of five responses) for some subjects, but serves to provide a general understanding of the areas of professional nursing involvement represented.

Table 6

Formalization, Centralization, and Job Satisfaction for Head Nurses and Staff Nurses

	Formalization		Centralization		Job satisfaction	
	Head nurse	Staff nurse	Head nurse	Staff nurse	Head nurse	Staff nurse
1 Low	1 (5.3%)	2 (1.2%)[a]		11 (6.4%)[b]		1 (.6%)[c]
2	2 (10.5%)	20 (11.7%)[a]	5 (26.3%)	34 (19.7%)[b]		8 (4.5%)[c]
3 Medium	6 (31.6%)	46 (26.9%)[a]	5 (26.3%)	50 (28.9%)[b]	1 (5.3%)	31 (17.4%)[c]
4	8 (42.1%)	64 (37.4%)[a]	5 (26.3%)	48 (27.7%)[b]	18 (94.7%)	126 (70.8%)[c]
5 High	2 (10.5%)	39 (22.8%)[a]	4 (21.1%)	30 (17.3%)[b]		12 (6.7%)[c]
Range	1-5	1-5	2-5	1-5	3-4	1-5
Mean	3.42	3.69	3.42	3.30	3.95	3.79
SD	1.02	.99	1.12	1.16	.23	.65

[a]Twelve missing observations.

[b]Ten missing observations.

[c]Five missing observations.

concentrated in a few people. The mean score for the head nurses was 3.42 (see Table 6).

Job satisfaction was rated on a Likert scale, with 1 representing low job satisfaction and 5 representing high job satisfaction. The head nurses had a mean score of 3.95 (see Table 6).

Description of Staff Nurses

The sample size of staff nurses was 183. Of these, 57.4% were employed by Hospital A, and 42.6% were employed by Hospital B.

Based on figures given by the head nurse, the percentage of staff nurse participation for each unit ranged from 9.1% to 88.9%. Average participation was 47.8%. The number of staff nurse participants per unit ranged from 4 to 21.

The majority of staff nurses was female, accounting for 87.8% of the sample; 12.2% were male. Approximately half (48.0%) had their BSN degree.

More than half of the staff nurses (56.1%) had practiced nursing for 8 years or more. Approximately half (47.0%) had been supervised by their head nurse for 6 months to 1 year. Roughly one-third (33.1%) had been supervised by their head nurse for 2 to 3 years.

Approximately two-thirds (66.5%) worked the day shift; 44.2% worked an 8-hour shift; and 22.3% worked a 12-hour shift. Evening- and night-shift people comprised

the additional third (33.5%); 15.6% worked an 8-hour evening shift; 6.7% worked an 8-hour night shift; and 11.2% worked a 12-hour night shift. The Baylor Plan was worked by 7.8% of the staff nurse sample. Only 26.5% of staff nurses recorded that they interacted with their head nurse every day; 32.6% recorded that they interacted three to four times per week; and 40.9% interacted with their head nurse only once or twice per week.

Less than half (45.8%) were members of a professional nursing organization; 54.2% were not. Of those who had membership with a professional nursing organization, 74.1% belonged to one organization, and 25.9% belonged to two or more organizations. The degree of professional involvement is presented by a multiple-response cross-tabulation (see Table 5), comparing staff nurses with head nurses. More than half (57.7%) read publications of professional nursing organizations or attended educational offerings or conventions (57.1%).

Formalization and centralization are defined and explained in the Description of Head Nurses section. The mean score for the staff nurses for formalization was 3.69. The mean score for centralization was 3.30. Job satisfaction was measured for staff nurses, and a mean score of 3.79 was obtained. See Table 6 for a comparison of these variables by head nurse and staff nurse.

Internal Consistency of Instruments

Internal consistency of the IRI and LBDQ-XII instruments was investigated using Cronbach's alpha coefficient. A summary for this study is located in Table 7. The alpha coefficients for this study were very similar to those cited by Mansen (1988) for his study, which looked at role-taking abilities of nursing education deans/department chairpersons and their leadership effectiveness as evaluated by faculty.

Alpha reliabilities for the IRI scales of Fantasy and Perspective Taking were .70 and .74, respectively. These are identical to Mansen's (1988) study. The overall alpha of the IRI used in this study was .72. Mansen reported .74 for his study. Initial alphas reported by Davis (1980) indicated that for the Fantasy scale, males had an alpha of .78 and females had an alpha of .79. Davis reported alphas of .71 for males and .75 for females for the Perspective Taking scale.

The alpha reliability for the Initiating Structure scale of the LBDQ-XII for this study was .78. The Showing Consideration scale yielded an alpha of .90. Mansen (1988) specified alpha reliabilities for the Initiating Structure and Showing Consideration scales to be .77 and .90, respectively. The overall alpha for the LBDQ-XII for this study was .89, identical to that obtained by Mansen in his study. From a study involving college presidents,

Table 7

Reliability Analysis (Summary) for Leadership Behavior Description Questionnaire-XII and Interpersonal Reactivity Index

Instrument	Alpha
IRI*	.72
Fantasy	.70
Perspective Taking	.74
LBDQ-XII	.89
Initiating Structure	.78
Showing Consideration	.90

*Staff nurses and head nurses were combined for the analysis.

Stogdill (1963) reported an alpha of .76 for the Showing Consideration scale of the LBDQ-XII, and .80 for the Initiating Structure scale.

Analysis of Research Hypotheses

Prior to discussing the data analysis as it relates to the research hypotheses, raw data scores of the two dimensions of leadership effectiveness are discussed. Leadership effectiveness, as determined by the original LBDQ, is represented by the relative position of the individual scores on each of the two dimensions of leader behavior (Halpin, 1957). The average scores obtained for each leader from the individuals who rated them are

determined for each of the two dimensions. Each leader's scores were plotted by placing the axis of the two dimensions perpendicular to each other at their midpoint. Each set of scores places the leader in one of four categories. The midpoint for this study was 20, based upon a possible total score of 40 for each dimension. Individuals were plotted in Category I, whose average scores were above the midpoint on both dimensions. Categories II and IV had individuals whose scores were above the midpoint on one dimension but below the midpoint on the other dimension. Category III had individuals whose scores were below the midpoint on both dimensions. This model, as it relates to this study, is depicted in Figure 2. Raw data for individual scores is specified in Table 8 and have been rounded to whole numbers for plotting purposes. Points that have been plotted reflect the mean scores, but they do not represent the standard deviation. Figure 2 is meant to provide a pictorial description; however, one should consider both the mean and standard deviation to have a complete understanding. Those points that are on or near the axis might otherwise be placed in a different category when the standard deviation is considered. Based upon this model, effective leaders are expected to fall into Category I, having average leadership effectiveness scores, as rated by their followers, to be above the midpoint on both

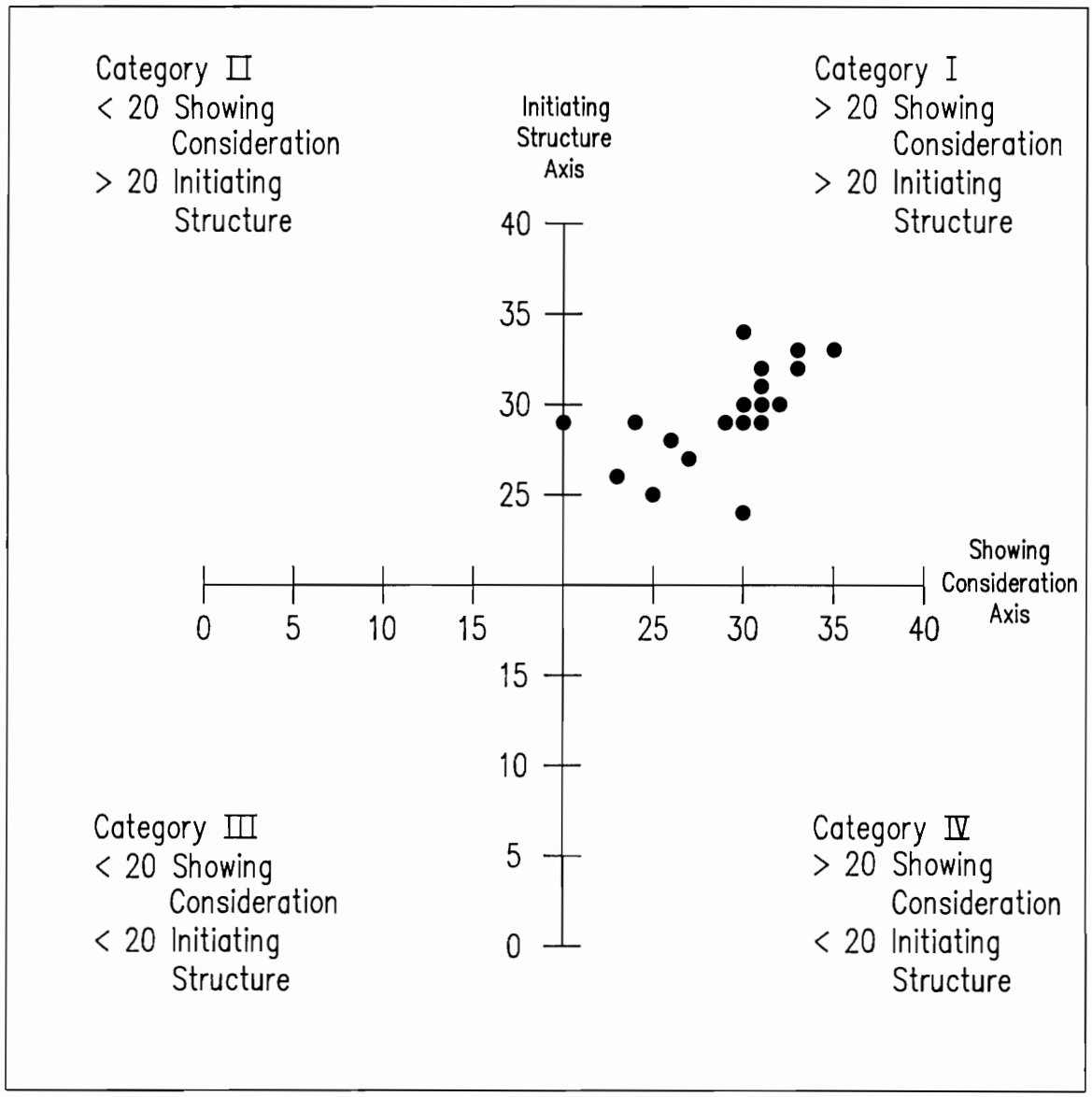

Figure 2. Categories formed by leadership dimension of Leadership Behavior Description Questionnaire-XII and scores of the head nurses as rated by their staff nurses.

Note. Leaders may be placed in one of four categories based upon their mean scores on each of the two dimensions of leadership effectiveness. Effective leaders are placed in Category I.

Table 8

Initiation of Structure and Consideration Scales of Leadership Behavior Description Questionnaire-XII by Head Nurse

	Structure		Consideration	
Subject number	Mean	SD	Mean	SD
1	29.88	4.88	32.06	6.11
2	33.00	4.69	34.50	3.70
3	32.56	3.40	33.22	3.15
4	29.00	4.06	19.78	6.20
5	32.11	5.69	33.33	5.29
6	28.86	4.98	29.71	9.34
7	28.71	5.53	28.71	7.25
8	29.00	4.24	30.67	5.61
9	24.00	3.89	29.50	5.15
10	26.25	3.88	22.63	5.50
11	24.75	4.50	25.25	5.74
12	34.00	4.28	30.43	5.03
13	26.50	3.62	26.67	5.16
14	32.11	5.37	30.67	5.70
15	28.65	4.18	24.00	5.94
16	29.71	3.59	30.00	5.45
17	30.65	4.72	29.82	5.49
18	30.00	4.03	31.11	4.11
19	27.56	3.36	25.67	8.32
Total	29.42	4.89	32.06	6.11

dimensions (Hoy & Miskel, 1987). For this study, all but 1 head nurse (94.7%) were placed in Category I. The other head nurse (5.3%) was located on the axis between Category I and Category II.

Research Hypothesis 1

> There will be no relationship between self-rated, role-taking abilities of head nurses and ratings of their leadership effectiveness as rated by a sample of their staff nurses, while controlling for possible effects of role-taking abilities of the staff nurses.

Analysis of the data associated with scores obtained on the IRI and LBDQ-XII is summarized in Table 9. The relationship between the score and the dimensions of Showing Consideration and Initiating Structure of the LBDQ-XII used to measure leadership effectiveness has already been discussed (see Figure 2). Scores obtained from the IRI do not allow for the same comparison to be drawn in reference to the score's relationship to a midpoint. In the development of the IRI, Davis (1980) did not draw any conclusions as how to interpret high or low scores.

This hypothesis was examined using two different methods. The first method is consistent with that used by Mansen (1988), in which he used the average score for the faculty's rating as the score for the nursing education dean/department chairperson. For this study, using this aggregate method, the unit of analysis is the head nurse

Table 9

Range, Mean, and Standard Deviation for Variables Associated with Role-Taking Abilities and Leadership Effectiveness

	Possible range[a]	Mean	SD
Head nurses			
IRI	0-56	34.0	6.12
Perspective Taking	0-28	20.6	4.0
Fantasy	0-28	13.4	3.6
Staff nurses			
IRI	0-56	33.4	7.8
Perspective Taking	0-28	19.0	4.9
Fantasy	0-28	14.4	5.4
LBDQ-XII	0-80	58.1	10.3
Initiating Structure	0-40	29.4	4.9
Showing Consideration	0-40	28.7	6.8

[a]Range reflects the total scope of instrument.

Note. IRI = cognitive empathy (Perspective Taking and Fantasy); LBDQ-XII = leadership effectiveness (Initiating Structure and Showing Consideration).

or nursing unit. A drawback to this method of analysis is that a staff nurse from a unit with a large number of respondents will carry less weight in the statistical analysis than a staff nurse from a unit with only a few respondents.

The second method paired each individual staff nurse with his or her head nurse. Using this method, the

individual staff nurse becomes the unit of analysis. This allowed for each staff nurse who responded to have an equal representation in the statistical analysis. However, with this method, a head nurse having a large number of staff nurses responding is then given more weight in the statistical analysis than a head nurse with only a few staff nurses responding.

Pearson correlation coefficients were calculated using the statistical software package of the Statistical Package for Social Sciences (SPSS) (SPSS-X Inc., 1990). These data were treated as interval data, and Pearson correlation coefficients are presented in Table 10 for both the aggregate and individual methods. No statistically significant correlations were found. Role-taking ability was evaluated using both scales of the IRI individually (i.e., Perspective Taking and Fantasy scales), as well as a combined score of both scales measuring cognitive empathy (i.e., IRI). Leadership effectiveness was evaluated using both scales of the LBDQ-XII individually (i.e., Initiating Structure and Showing Consideration), as well as a combined score measuring leadership effectiveness (i.e., LBDQ-XII). Mansen (1988) did not evaluate leadership effectiveness as a combined score; however, the literature supports the premise that this is appropriate since the scales are not independent of each other (Bass, 1981; Dipboye, 1978; Lake et al.,

Table 10

Pearson Correlation Coefficients

	Staff nurses					
	LBDQ-XII		Initiating structure		Showing consideration	
Head nurses	Aggregate[a]	Individual[b]	Aggregate[a]	Individual[b]	Aggregate[a]	Individual[b]
IRI	-.18	-.12	-.19	-.09	-.15	-.11
Fantasy	-.12	-.07	-.12	-.06	-.09	-.06
Perspective Taking	-.18	-.11	-.19	-.08	-.14	-.11

[a]Aggregate: aggregate staff nurse unit of analysis.

[b]Individual: individual staff nurse unit of analysis.

1973).

For each method, a partial correlation analysis was conducted to examine the linear relationship between self-rated, role-taking abilities of head nurses and leadership effectiveness as rated by staff nurses, while controlling for the linear effects of self-rated staff nurses' role-taking abilities upon each of the other two variables individually. No statistically significant correlations were found (see Table 11).

To investigate further, Pearson correlation coefficients were computed bivariately among these three variables (see Table 12). Table 12 clearly shows that for the exception of two very weak, but significant, negative correlations (i.e., Fantasy scale correlated with Initiating Structure scale at -.18, and Fantasy scale correlated with combined LBDQ-XII at -.16), nothing is correlated.

In response to research Hypothesis 1, no statistically significant correlations were found that related to the role-taking abilities of the head nurse as compared to the leadership effectiveness scores provided by the staff nurses. The null hypothesis is therefore accepted since no relationship related to the first research hypothesis that was found to exist in this research study.

Table 11

Partial Correlation Coefficients

	Staff nurses						
	LBDQ-XII		Initiating Structure		Showing Consideration		Controlling for staff nurses
Head nurses	Aggregate[a]	Individual[b]	Aggregate[a]	Individual[b]	Aggregate[a]	Individual[b]	
IRI	-.21	-.12	-.21	-.09	-.17	-.12	IRI
Fantasy	-.11	-.07	-.12	-.06	-.09	-.06	Fantasy scale
Perspective Taking	-.24	-.12	-.55	-.09	-.19	-.12	Perspective Taking

[a]Aggregate: aggregate staff nurse unit of analysis.

[b]Individual: individual staff nurse unit of analysis.

Table 12

Pearson Correlation Coefficients Computed Bivariately Among Variables of Partial Correlation Analysis

	Staff nurses			Head nurses		
Staff nurses	LBDQ-XII	Initiating Structure	Showing Consideration	IRI	Fantasy	Perspective Taking
IRI	-.03	-.04	-.02	.07	.09	.03
Fantasy	-.16*	-.18*	-.12	.00	.01	.00
Perspective Taking	.13	.14	.10	.12	.14	.05

*$p < .05$.

Research Hypothesis 2

> There will be no relationship between role-taking and situational/demographic variables (i.e., organizational characteristics, educational preparation of head nurses and staff nurses, length of time employed in nursing, length of time supervised by head nurses, length of time in supervision for head nurses, degree of professional activity, interaction time between head nurses and staff nurses, and job satisfaction).

Both parametric (Pearson) and nonparametric (Spearman) correlational analyses were performed, where appropriate, for the demographic variables to evaluate what their relationship was with role-taking ability (see Table 13). A statistically significant weak parametric correlation of .18 ($p < .05$) and nonparametric correlation of .22 ($p < .01$) were found for formalization and the Perspective Taking scale of the IRI, which were present only among the staff nurses.

In response to research Hypothesis 2, only one demographic variable, formalization, was found to correlate slightly with role-taking abilities. A low, although significant, correlation was found among staff nurses between formalization and role-taking ability. The null hypothesis is accepted, in that no relationship exists between role-taking ability and the specified demographics, with the exception of formalization.

Table 13

Pearson and Spearman (in Parentheses) Correlation Coefficients for Demographic Variables Correlated with Role-Taking Abilities

	IRI	Fantasy	Perspective Taking
Head nurses			
Formalization	.18 (.23)	.14 (.09)	.15 (.17)
Centralization	-.04 (-.12)	-.04 (-.11)	-.03 (-.12)
Job satisfaction	.16 (.17)	-.11 (-.20)	.34 (.33)
Staff nurses			
Formalization	.09 (.05)	-.04 (-.07)	.18*(.22)**
Centralization	-.06 (-.09)	.00 (.01)	-.10 (-.11)
Job satisfaction	.05 (.10)	.03 (.05)	.05 (.09)

*$p < .05$.

**$p < .01$.

Research Hypothesis 3

> There will be no relationship between leadership effectiveness and situational/ demographic variables (see Hypothesis 2).

Correlational analyses were performed, where appropriate, for the demographic variables to evaluate what their relationship was with leadership effectiveness. Both parametric (Pearson) and nonparametric (Spearman) analyses were conducted in most cases (see Table 14). Of the head nurse sample, only length of time in nursing and years of education were found to correlate with the combined LBDQ-XII score and the scale Showing Consideration. Both these demographics had weak negative correlations, which were calculated with nonparametric statistical techniques.

Of the staff nurse sample, the demographics that correlated with leadership effectiveness were the organizational characteristics of formalization and centralization, job satisfaction, and years of education. Formalization had a mild positive correlation with the combined LBDQ-XII score of .25 ($p < .001$). Initiating Structure scale correlated slightly stronger with formalization at .32 ($p < .001$). A very low correlation was found between the Showing Consideration scale and formalization of .15 ($p < .05$).

Centralization was negatively correlated with leadership effectiveness on the combined LBDQ-XII score at

Table 14

Pearson and Spearman (in Parentheses) Correlation Coefficients for Demographic Variables Correlated with Leadership Effectiveness

	LBDQ-XII		Initiating Structure		Showing Consideration	
Head nurses						
Length of time in nursing		(-.22)**		(-.12)		(-.24)***
Years of education		(-.16)*		(-.11)		(-.17)*
Staff nurses						
Formalization	.25***	(.27)***	.32***	(.34)***	.15*	(.16)*
Centralization	-.19**	(-.17)*	-.01	(.00)	-.28***	(-.25)***
Job satisfaction	.32***	(.25)***	.30***	(.27)***	.27***	(.19)**
Years of education		(.11)		(-.04)		(.21)**

*$p < .05$.

**$p < .01$.

***$p < .001$.

-.19 ($p < .01$). Showing Consideration also was negatively correlated with centralization at -.28 ($p < .001$).

Job satisfaction was mildly positively correlated with all three measurements of leadership effectiveness. Combined LBDQ-XII, Initiating Structure, and Showing Consideration had correlations of .32, .30., and .27, respectively ($p < .001$).

Years of education had a weak positive correlation with Showing Consideration. The r value was .21 ($p < .01$).

In response to research Hypothesis 3, only weak to mild correlations could be found among some of the demographic variables to leadership effectiveness. Years of education was the only demographic variable that was correlated with Showing Consideration in both the head nurse and staff nurse samples, although it was negatively correlated with the head nurse group and positively correlated with the staff nurse group. The null hypothesis is accepted for the majority of the demographic variables in relation to leadership effectiveness. It is rejected based on correlation coefficients between leadership effectiveness and years of education for both head nurses and staff nurses and for staff nurses only between leadership effectiveness and formalization, centralization, and job satisfaction. For these relationships, the alternate hypothesis is accepted,

stating that there is a relationship, although only weak to mild.

Summary

This chapter presented the results of the data collection and data analysis. Included was a description of the reliability inventories of the instruments calculated for this study sample. A discussion of the data analysis as it related to each of the three research hypotheses concluded this chapter.

CHAPTER V

DISCUSSION

The purpose of this chapter is to discuss the results of this research study. Identification of results and conclusions is presented, and implications for nursing are discussed. It will conclude with recommendations for further research.

Results

The results described are obviously limited by the nature of this particular sample. This study was an exploratory examination of (a) role-taking ability of head nurses and staff nurses, (b) leadership effectiveness of the head nurse as perceived by the staff nurses, and (c) evaluation of the relationship between role-taking ability of head nurses and their leadership effectiveness as perceived by staff nurses. This study was a replication of an investigation conducted by Mansen (1988), who examined the relationship between role-taking abilities and leadership effectiveness of nursing education deans/department chairpersons and nursing faculty. In the current study, leaders were the head nurses and followers were members of their staff nurses.

For purposes of this study, role-taking ability was

viewed as a process. The focus of role-taking ability was the skill with which to demonstrate behaviors associated with the concept of role taking as opposed to accurately predicting actions or feelings of others. This was measured by the IRI, which is composed of two scales: (a) Perspective Taking and (b) Fantasy.

Leadership effectiveness was measured by the LBDQ-XII, which also is composed of two scales: Initiating Structure and Showing Consideration. The relationship of these two dimensions was diagrammed in Figure 2. Most head nurses (n = 18) were categorized to be effective leaders, as rated by their staff nurses to be above the midpoint on both dimensions. The other individual was at the midpoint for Showing Consideration and above the midpoint for Initiating Structure.

Analysis of the data related to the first research hypothesis did not result in any statistically significant correlations to demonstrate a relationship between role-taking abilities of head nurses and their leadership effectiveness as evaluated by staff nurses. Mansen (1988) found a significant correlation (.36) between role-taking abilities of the nursing education deans/department chairpersons and the faculty's perception of his or her leadership effectiveness related to the Showing Consideration dimension of leadership behavior. He found a stronger correlation (.49) was evident when only the

Perspective Taking scale was used. His results supported previous research that found significant relationships between empathy and the consideration dimension of leadership behavior (Fleishman & Salter, 1963). Research conducted prior to Mansen's study, examining empathy and leadership behavior, studied empathy as a unidimensional concept; thus, direct comparisons are not available.

Weak, but significant, negative correlations were found between the Fantasy scale and both the LBDQ-XII score (-.16) and Initiating Structure scale (-.18). Mansen (1988) correlated the Fantasy scale with the Initiating Structure scale at -.65. He attributed his results to indicate that individuals scoring higher on the Fantasy scale may be more prone to abstractness and might need more structure to function within an organizational environment. This also may apply to the nursing practice setting, thus explaining the negative correlation found in this research study.

Investigation of the relationship between role-taking abilities of the head nurses and role-taking abilities of the staff nurses produced no statistically significant correlations. This finding supports Mansen's (1988) findings. No other literature addresses this relationship. Initial studies of empathy and leadership investigated leaders' empathic ability but did not address the role of empathy in the followers or a relationship

between empathic abilities of leaders and followers.

Why were there no significant correlations from the area of nursing practice regarding the major focus of this research study, i.e., the relationship of role-taking abilities of head nurses to leadership effectiveness, when significant correlations were found in the area of nursing education? Most of the head nurses involved in this study were evaluated by their staff nurses to be effective leaders. Possible explanations for different results with this nursing practice sample follow. Some of these explanations are mere speculation on the part of this investigator but may help shed some light on this study's results.

The homogeneity of the two groups may account for the lack of statistically significant results related to the first research hypothesis. This is particularly evident with the demographic data as shown in Table 1. Greater than half had been in nursing for 8 years or more. Approximately half of the subjects had education levels at the BSN. Approximately half were members of a professional nursing organization. The mean scores between the groups of head nurses and staff nurses for formalization, centralization, and job satisfaction were not dramatically different.

The sample size was small, i.e., only 19 nursing units were represented from only two hospitals in close

geographic proximity. An increase of the number of head nurses may have yielded different results. The level of participation from staff nurses varied from 9.1% to 88.9%. A defined level of staff nurse involvement could have improved the sample. An increase in the number of institutions also may have provided different results. A random-sampling technique is preferable to the type of convenience sampling employed for this research.

Regarding the data collection procedure, questionnaires were given to staff nurses at regularly scheduled staff meetings or at shift change when staff meetings were not available for the investigator to attend. Some of the staff meetings appeared to have such lengthy agendas that staff nurses may not have been in the best frame of reference to participate in this research study. When the data collection occurred at shift change, the staff nurses were generally very busy. This also may have affected not only those who chose to participate but also the amount of time they had to devote to the questionnaires.

There may be differences in the organizational characteristics between the nursing-education area and the nursing-practice area, specifically the hospital setting. Mansen (1988) suggested that in replicating his study one should decrease the administrative layers between the leaders and followers. This was accomplished for this study, but the decrease in administrative levels between

the leaders and the followers may have contributed to different interpretations of the organizational characteristics of formalization and centralization, as compared to Mansen's study. The literature supports the fact that organizational variables exert influence upon leaders (French et al., 1985; Gibb, 1974).

The sample from the nursing-education population of Mansen's (1988) study had different characteristics as compared with the sample of this study. Those from Mansen's study consisted of numerous doctorally prepared individuals and individuals with tenure. These individuals may possess greater job security as contrasted to the head nurses and staff nurses in a hospital setting. Possibly, this relates to the dissimilar results of this study where no significant correlations were found.

Regarding the reliabilities of the instruments used to measure the variables of this study, Carmines and Zeller (1987) cited that, as a general rule, reliabilities should not be below .80 for scales that are widely used. They explained that at this level correlations are attenuated very little by random measurement error. Munro, Visintainer, and Page (1986) maintained that a level of .80 is considered "good." The LBDQ-XII has been widely used since its publication in 1962, exceeding the alpha level of .80. The IRI, however, is a relatively new instrument and has not been widely used. In addition, it

does not meet the .80 alpha level recommended. Carmines and Zeller also stated that it is difficult to indicate a single level that should apply in every situation. The IRI may need to have some items reworded to more accurately measure the concept of cognitive empathy or, more specifically, role-taking ability (i.e., Perspective Taking scale). The IRI was chosen for this study due to its concise nature and modest number of items needing response by study participants. However, a scale with only seven items may need to be expanded to account for all factors contributing to the measurement of role-taking ability with the Perspective Taking scale.

The LBDQ-XII is not without its problems, even though it meets the recommended alpha level of .80. The Initiating Structure scale has had implications related to punitive and authoritarian behavior. The LBDQ-XII was revised from the original LBDQ to reduce emphasis on punitive and authoritarian behavior by stressing psychological structure. However, as Mansen (1988) pointed out, one might question whether the behaviors addressed in the Initiating Structure scale do, in fact, differentiate between the punitive and authoritarian behavior and the psychological structure enough to produce a significant relationship between role-taking and leadership effectiveness.

The second research hypothesis examined the

relationship between demographic variables to role-taking ability. Correlations found related to this hypothesis would have been more meaningful if statistically significant correlations had been found for the first research hypothesis.

A very low, but significant, correlation of .18 was found among staff nurses between formalization and role-taking abilities. This may signify only a trend in that the more rules were used to ensure continuity and consistency, the more the staff nurse was able to practice role taking.

The third research hypothesis examined the relationship between the demographic variables and leadership effectiveness. This, too, would have had more impact had a statistically significant correlation been found for the first research hypothesis.

The demographic variable of years of education correlated with the Showing Consideration scale for both the head nurses and staff nurses: -.17 and .21, respectively. This demographic variable correlated negatively with head nurses but positively with staff nurses. The more the head nurse was educated, the lower his or her staff nurses scored him or her on Showing Consideration. Possibly the more education of the head nurse, the less he or she focused on consideration of followers. However, the more the staff nurse was

educated, the higher he or she scored the head nurse on Showing Consideration. Some staff nurses had more education than their head nurse. This occurred in 9.5% of the staff nurses. This may contribute somewhat to the opposing results of this study, as compared to Mansen's (1988) study.

Negative correlations were found among the head nurse group between length of time in nursing and how staff nurses rated them on both the LBDQ-XII and Showing Consideration scale: -.22 and -.24, respectively. Approximately half of the staff nurses (47.2%) had been in nursing for 8 years or more and worked for head nurses who had been in nursing for 8 years or more. Only 8.9% worked for head nurses who had not been in nursing as long as they had. The longer the head nurse had been in nursing, the lower the score given them by their staff nurses on leadership effectiveness. This requires further research to evaluate before any conclusions are drawn, particularly since the correlation coefficients are so low.

Among the staff nurses, correlations with their ratings of the leadership effectiveness of the head nurse were statistically significant with the demographic variables of formalization, centralization, and job satisfaction. Formalization was correlated with the combined LBDQ-XII score, Initiating Structure scale, and Showing Consideration scale. From the practical

standpoint, it stands to reason that the greater the formalization regarding rules and regulations present in an organization, the more it may prescribe, or at least influence, the amount of consideration the head nurse could show. It also may be indicative of how the structure dimension is employed by the head nurse.

Centralization was inversely correlated with the combined LBDQ-XII score and the Showing Consideration scale. The higher the centralization, or the fewer people given administrative authority to make decisions, the lower the ratings of leadership effectiveness--particularly from the consideration perspective. The more decentralized that decision making is, the more the staff nurse may feel he or she is given consideration by the head nurse. Drucker (1972) identified advantages of decentralization as less conflict between leaders and followers and a sense of fairness when dealing with leaders. This directly relates to high consideration.

Job satisfaction was found to correlate with the combined LBDQ-XII score, Showing Consideration scale, and Initiating Structure scale. The higher the job satisfaction experienced by the staff nurse, the higher the leadership effectiveness scores given to the head nurse. This result is supported extensively by the literature (Hoover, 1984; Lowin et al., 1969; Mansen, 1988; Szilagyi & Keller, 1976). All of these studies

resulted in a positive correlation between consideration and job satisfaction. From a common-sense perspective, the greater the staff nurses' job satisfaction, the more consideration felt to be received from the head nurse. The better the staff nurse felt he or she was treated influenced the overall job satisfaction that was experienced.

A positive correlation was found between job satisfaction and initiation of structure; this is supported by the literature (Mansen, 1988; Szilagyi & Keller, 1976). However, negative and insignificant correlations also have been reported (Bass, 1981). The relationship between initiation of structure and staff nurses' job satisfaction may be dependent upon other factors that affect the staff nurses' need for structure.

Conclusions

Analysis of the data provides no support to show that a relationship exists between role-taking abilities of head nurses and their perceived leadership effectiveness as rated by staff nurses. The overall ratings of the head nurses in this study indicated that most of them were rated as effective leaders by members of their staff nurses; however, no statistically significant correlation could be found with the head nurses' role-taking ability.

It is concluded that the role-taking abilities of the staff nurses do not have a distinct impact on the role-

taking abilities of the head nurse. The role-taking abilities of the staff nurses do not influence how they rated the leadership effectiveness of the head nurse.

Correlations between the demographic/situational variables and either role-taking ability or leadership effectiveness would have been more meaningful if significant correlations had been found related to role-taking ability of the head nurse and leadership effectiveness. Some weak to mild correlations were found relating some of the demographics to either role-taking ability or leadership effectiveness.

A conclusion from this study's results is the greater the length of time in nursing for head nurses, the lower the leadership effectiveness scores as rated by staff nurses. These variables correlated negatively, particularly with the consideration dimension and the combined LBDQ-XII score. It is possible that head nurses who have been in nursing for a considerable length of time lose some of what it takes to be an effective leader if they are not consistently trying to stay current with the nursing management literature and practices.

A correlation of this study is the positive relationship between staff nurses' job satisfaction and ratings of leadership effectiveness given the head nurse. This was evident by both scales of the LBDQ-XII: Initiating Structure and Showing Consideration. In other

words, the degree of job satisfaction experienced influenced how the staff nurse rated the head nurses' Showing Consideration dimension and Initiating Structure dimension, or vice versa.

Centralization was negatively correlated with both the combined LBDQ-XII score and the consideration dimension. It is concluded that the more decentralized the nursing unit is regarding decision making, the higher the staff nurse rated the head nurse on the consideration dimension of leadership effectiveness or the more the staff nurse may feel he or she is given consideration by the head nurse.

The last conclusion is that the more formalization present in the nursing unit, the higher the scores given the head nurse on leadership effectiveness. The higher the degree of institutional formalization as to rules and regulations, the higher the staff nurses rated the head nurse, particularly on the Initiating Structure dimension.

Implications for Nursing

This study can be directed only towards nursing leaders in the head nurse role in the hospital setting. No significant correlations were found to be present relating the head nurses' role-taking ability to the perceived leadership effectiveness as rated by staff nurses. Mansen (1988) found significant correlations of these two variables in the nursing education setting:

> Role taking has been identified as being a developmental process enhanced through the process of socialization. If there is interference with the socialization process, either on an individual or corporate level, then it could be expected that the ability to learn and/or practice role taking would not occur and the influence of one group upon the other would not happen. (pp. 127-128)

With role-taking ability identified as a developmental process, it is individually achieved. The degree to which the head nurses in this study may or may not have reached their full potential to role take is important to consider, especially since some adults reach their full potential and some do not.

There are two organizational processes that affect role-taking ability. These are the organizational processes during the educational experience while learning to become a nurse and the organizational process evident in the institutional setting where the nurse works.

Since correlations were evident between role-taking abilities and leadership effectiveness in the nursing education setting (Mansen, 1988), one can assume that role taking does occur in this setting. Perhaps this ability is not passed on by the nursing education dean/department chairperson to the faculty as valuable in the education of nursing students. It also is possible that if this is valued by the faculty it still may not be part of the curricula in the process of educating nursing students. Socialization in the educational process may not reinforce

the importance of role-taking ability to be used by nurses in the practice setting.

The organizational processes of the institution where the nurse works also may contribute to role-taking ability. If role-taking ability is taught during the educational process to become a nurse, it may not be valued by the institution where the nurse works. Role-taking ability may not be fully integrated at the staff nurse level to withstand carrying this concept with individuals to the head nurse level. Even if head nurses possess the ability to role take, it may not be supported or fostered from the nursing administration of the institution.

In the educational setting, the environment conducive to role taking may be present, whereas it may not be in the hospital setting. Many faculty are doctorally prepared or work where a tenure system is in place. This may lead to greater job security and promote the practice of role taking, particularly at the level of the nursing education dean/department chairperson. The head nurse does not have this type of job security or even work in the same type of environment. This may affect how the head nurse chooses to practice role taking in the hospital setting.

Recommendations

The survey research design and convenience sampling techniques allowed for the collection of data regarding the perception of role taking and leadership effectiveness based upon responses from head nurses and their staff nurses. Based upon these data and the results of this study, the following recommendations are made.

Replication

Replication of this study is indicated. This would establish the limits of this study's findings and methodology. This is especially important when Mansen (1988) had significant correlations in the nursing education setting, even though this study did not have significant correlations in the hospital setting. Other areas of nursing practice would be of benefit to study, e.g., public health. Other types of hospital settings may provide different results or comparisons, e.g., not-for-profit versus for-profit. A larger sample size would be beneficial, as well as a defined percentage of followers needed for each leader, to increase follower participation.

Mansen (1988) explored the relationship between nursing education deans/department chairpersons and faculty examining the highest position in nursing education as the leader. A suggestion for replication would be to examine the highest position in a hospital

setting, the nursing director as the leader, evaluated by head nurses as the followers. This would still accomplish having few administrative levels between leader and followers, as was recommended by Mansen (1988) in his suggestions for replication.

A different method for data collection is advisable; thus, study participants would not have the pressures associated with completing the questionnaires during the specified time limits of the staff meeting or at shift change.

Organizational characteristics of formalization and centralization, as well as job satisfaction, need to be expanded upon for replication. In this study, keeping the questionnaires at a succinct length, thus preventing individuals from participating, may have eliminated obtaining enough information to measure appropriately these variables.

Additional demographic variables of interaction time and working hours need to be refined to fully evaluate their relationship to role-taking ability and leadership effectiveness. Mansen (1988) recommended in replicating his study that interaction time be addressed. It was not, however, addressed in this study specifically enough to yield any significant impact on the findings.

Use of the IRI to measure role taking, based on the reliability analysis of this study, suggests that a

different instrument might more suitably measure this concept. The recommended alpha level for use of an instrument is .80 (Carmines & Zeller, 1987; Munro et al., 1986). The alpha coefficient for this study was .72. Mansen (1988) reported an alpha of .74 for his study. The literature, however, supports the use of this instrument to measure role taking (Chlopan et al., 1985; Davis, 1980, 1983). This aspect needs to be examined closely prior to replication. Possibly, some refinement of the IRI could yield better results in studying role taking.

The variable of leadership effectiveness was narrowly defined in this study, measuring only two dimensions: Initiating Structure and Showing Consideration. In replicating this study, the variable of leadership effectiveness should be redefined. The concept of leadership style could yield a stronger relationship to role taking. Use of other instruments to measure leadership effectiveness may address additional aspects of leadership not possible within the narrow scope of this study.

Develop Interventions Aimed at Strengthening Role-Taking Abilities

Interventions that would strengthen or facilitate the incorporation of role taking into leadership practice could be developed for head nurses. Examining the relationship between role-taking and leadership

effectiveness before and after the intervention could possibly show that role-taking ability correlates with effective leadership among head nurses. Mansen (1988) found significant correlations in the nursing education setting when examining these same variables.

The developmental process of role-taking ability has been identified as a leadership skill. Holle and Blatchley (1989) asserted that leadership skills can be learned. Gladstein (1983) reported that therapists are capable of learning role taking. Therefore, it is postulated that head nurses also are capable of learning role taking.

It should be noted that Selman's final and mature stage in social cognition development is social perspective-taking ability, or role-taking ability, which is not reached by all adults (Muuss, 1982)--particularly since it has been identified as a developmental process. This concept needs to be considered when evaluating the usefulness of teaching role-taking ability. Prior to applying any interventions, further study into this relationship of role-taking and leadership effectiveness is essential.

Summary

This chapter presented the results of this research study; it included identification of the major results and conclusions. Implications for nursing were taken from the

data analysis. This chapter concluded with recommendations for further research related to role-taking abilities of head nurses and their leadership effectiveness.

APPENDIX A

CONSENT LETTER AND RESPONSE FORM: HEAD NURSE

Consent Letter

Dear Head Nurse:

You are invited to participate in a study examining the relationship between role-taking abilities and leadership effectiveness. Effective leadership requires a dynamic, positive interaction between leaders and followers. Few studies have been undertaken that examine leadership characteristics that facilitate leadership effectiveness. The purpose of this study is to explore the relationship between role-taking abilities of head nurses and staff nurses and their ratings of leadership effectiveness. A major benefit of this study is that the research results may be used to improve management development programs. The study is entitled "The Relationship Between Role-Taking Abilities of Head Nurses and Their Perceived Leadership Effectiveness."

Head nurses from two Salt Lake area hospitals are being contacted to provide information on role-taking abilities and its relationship to leadership behaviors. If you have been in your current head nurse position for 1 year and volunteer to participate, I would like to attend one of your staff meetings so I could explain my study and give staff nurses the opportunity to participate. Your assistance is vital in providing significant information about the relationship that exists between role-taking and leadership effectiveness. Please complete the enclosed form and return it to me in the enclosed stamped, self-addressed envelope regarding whether you volunteer to participate, or not. Please indicate a time for me to meet with you and your staff nurses. This can be your next regularly scheduled staff meeting. I will follow up with you to confirm.

The questionnaires for the head nurses request information on demographics and information regarding role-taking ability. The staff nurses would provide information related to role-taking ability and ratings of leadership behavior as well as complete a questionnaire on demographics.

Your voluntary participation in this study would require approximately 15 minutes of your time to complete the questionnaires described above. You are under no obligation to participate in this study. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. Your completing and returning of the questionnaires will be taken as evidence of your willingness to participate and your consent to have the information used for purposes of the study.

There are no known risks inherent in the study. Questionnaires will be coded for the purpose of matching head nurses with staff nurses. Any information obtained in the study that can be identified with you, your staff nurses, or your nursing unit will be kept strictly confidential. Preliminary/final data summary to requesting institutions within the study and/or publication will reflect aggregate data and comparisons to ensure individual anonymity. Please indicate with your returned questionnaire whether you would like to receive a summary of the results, along with your mailing address. Please retain this letter for an explanation about the nature of your participation and the handling of the information you supply.

If you have any questions regarding the questionnaires or the study, please feel free to contact me or my chairperson, Thomas J. Mansen, RN, PhD. I can be reached by phone at 756-9971 or at the following address: 11092 North 5600 West, Highland, Utah 84003. Dr. Mansen can be reached by phone at 581-5073 or at the following address: University of Utah, College of Nursing, 25 South Medical Drive, Salt Lake City, Utah 84112. If you have a problem that cannot be discussed with me or my chairperson, please feel free to contact the Institutional Review Board of the University of Utah at 581-3655.

Thank you for your cooperation and assistance with this study.

Sincerely,

Dawn Higley, RN
MS Candidate

Enclosures

Response Form

Head nurse name: _____

Institution: _____ Nursing unit: ____

Please check the appropriate response below:

_____ I consent to participate in the research study examining the relationship between role-taking abilities of head nurses and ratings of leadership effectiveness.

_____ I have not been in current head nurse position for 1 year, so am unable to participate.

_____ I do not wish to participate.

If you consent to participate, when is your next scheduled staff meeting that I could attend to give staff nurses the opportunity to volunteer to participate?

Date: _____ Time: _____

Phone number: _____

I will contact you to confirm the time to meet with you and your staff nurses. Thank you very much!

APPENDIX B

CONSENT LETTER: STAFF NURSE

Dear Staff Nurse:

You are invited to participate in a study examining the relationship between role-taking abilities and leadership effectiveness. Effective leadership requires a dynamic, positive interaction between leaders and followers. Few studies have been undertaken that examine leadership characteristics that facilitate leadership effectiveness. The purpose of this study is to explore the relationship between role-taking abilities of head nurses and staff nurses and their ratings of leadership effectiveness. A major benefit of this study is that the research results may be used to improve management development programs. The study is entitled "The Relationship Between Role-Taking Abilities of Head Nurses and Their Perceived Leadership Effectiveness."

Head nurses from two Salt Lake area hospitals are being contacted to provide information on role-taking ability and its relationship to leadership effectiveness. Your head nurse has volunteered to fill out a questionnaire on role-taking ability and a questionnaire to elicit demographic information. I also need staff nurses to participate in order to use the information I will obtain from head nurses. Staff nurses need to have worked for current head nurse for a minimum of 6 months in order to participate in this study.

I would appreciate it if you would complete the attached questionnaires. One requests demographic information; the others are related to role-taking abilities and leader behaviors. In order for the study to be complete, I need data from both the head nurses and staff nurses; therefore, your cooperation and involvement in this study is essential. The information obtained will provide insightful data as to the relationship between role-taking ability and leadership effectiveness.

Your voluntary participation in this study would require approximately 15 minutes of your time to complete the enclosed questionnaires. You are under no obligation to participate in this study. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. Your completing and returning of the questionnaires will be taken as evidence of your willingness to participate and your consent to have the information used for purposes of the study. There are no known risks inherent in the study. Questionnaires will be coded for the purpose of matching head nurses with staff nurses. Any information obtained in the study that can be identified with you, your head nurse, or your nursing unit will be kept strictly confidential. Preliminary/final

data summary to requesting institutions within the study and/or publication will reflect aggregate data and comparisons to ensure individual anonymity. Please indicate with your returned questionnaire whether you would like to receive a summary of the results, along with your mailing address. Please retain this letter for an explanation about the nature of your participation and the handling of the information you supply.

If you have any questions regarding the questionnaires or the study, please feel free to contact me or my chairperson, Thomas J. Mansen, RN, PhD. I can be reached by phone at 756-9971 or at the following address: 11092 North 5600 West, Highland, Utah 84003. Dr. Mansen can be reached by phone at 581-5073 or at the following address: University of Utah, College of Nursing, 25 South Medical Drive, Salt Lake City, Utah 84112. If you have a problem that cannot be discussed with me or my chairperson, please feel free to contact the Institutional Review Board of the University of Utah at 581-3655.

Thank you for your cooperation and assistance with this study.

Sincerely,

Dawn Higley, RN
MS Candidate

APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE: HEAD NURSE

Please respond to the following questions by circling the one response that best answers the question (unless otherwise instructed). If, after responding to a question you would like to make a comment, please feel free to do so in the margin. Thank you!

1. Gender:

   A. Male
   B. Female

2. Length of time in nursing:

   A. Less than 2 years
   B. 2 years to less than 4 years
   C. 4 years to less than 6 years
   D. 6 years to less than 8 years
   E. 8 years or greater

3. Education (highest degree):

   A. LPN
   B. RN (Diploma)
   C. RN (ADN)
   D. RN (BSN)
   E. RN (MS)
   F. RN (PhD)

4. Type of nursing unit (circle all that apply):

   A. Intensive Care Unit
   B. Medical
   C. Surgical
   D. Obstetrics
   E. Pediatrics
   F. Psychiatric
   G. Neurology
   H. Oncology
   I. Cardiac
   J. Orthopedics
   K. Operating Room
   L. Emergency Room
   O. Other (please specify): _____

5. Bed size of nursing unit:

   A. 1 - 10
   B. 11 - 20
   C. 21 - 30
   D. 31 - 40
   E. Greater than 40

6. Please fill in the number you have for each type of staff:

_____ Registered nurses
_____ Licensed practical nurses
_____ Aides/clerical

7. Length of time as supervisor of this nursing unit:

A. Less than 2 years
B. 2 years to less than 4 years
C. 4 years to less than 6 years
D. 6 years to less than 8 years
E. 8 years or greater

8. Length of time in supervision, other than present position as head nurse:

A. Less than 2 years
B. 2 years to less than 4 years
C. 4 years to less than 6 years
D. 6 years to less than 8 years
E. 8 years or greater

9. Average amount of time spent interacting with staff nurses:

A. Every day
B. 3 to 4 times per week
C. 1 to 2 times per week

10. What is your predominant shift?

A. 8-hour shift (days)
B. 8-hour shift (evenings)
C. 8-hour shift (nights)
D. 12-hour shift (days)
E. 12-hour shift (nights)

11. Do you ever work staff and provide patient care?

A. Yes
B. No (Please skip to Question 13.)

12. How often do you work staff?

A. 2 to 3 times per week
B. 1 time per week
C. 2 to 3 times per month
D. 1 time per month

13. Are you a member of a professional nursing organization?

    A. Yes
    B. No (Please skip to Question 15.)

14. Which organizations do you belong to? (Circle all that apply.)

    A. ANA
    B. NLN
    C. AACN
    D. AORN
    E. ONS
    F. NAACOG
    G. Other (please specify): _____

15. What is your degree of involvement in professional activities? (Circle all that apply.)

    A. No involvement at this time
    B. Read publications of association
    C. Participate in functions of association
    D. Attend educational offerings or conventions
    E. Committee member of association committee
    F. Hold an elected position

16. Using the following definitions of formalization, rank the nursing unit according to the degree of formalization present in the organization.

    Formalization: The degree that rules are used by the organization to ensure continuity and consistency.

    High formalization: Rules are used to guide almost all decisions. The nursing unit operates using clearly specified rules and procedure manuals.

    Low formalization: Rules are used to determine decisions only when necessary. The nursing unit operates with few written rules and procedures.

    1 2 3 4 5

    (LOW) (HIGH)

17. Using the following definition of centralization, rank the nursing unit according to the degree of centralization that describes the nursing unit.

    Centralization: Administrative authority to make decisions about the people.

    High centralization: Administrative authority is concentrated in a few people.

    Low centralization: Administrative authority is shared among many people.

    1 2 3 4 5

    (LOW) (HIGH)

18. How do you like working for this institution?

    A. It's not a very good place to work, would change almost everything.
    B. It's all right, but there are many things that should be changed.
    C. It's a fairly good place, but quite a few things should be changed.
    D. It's a good place, but there are a few things that should be changed.
    E. It's a very good place, wouldn't change anything.

Thank you very much for your participation in this study!

APPENDIX D

DEMOGRAPHIC QUESTIONNAIRE: STAFF NURSE

Please respond to the following questions by circling the one response that best answers the question (unless otherwise instructed). If, after responding to a question you would like to make a comment, please feel free to do so in the margin. Thank you!

1. Gender:

   A. Male
   B. Female

2. Length of time in nursing:

   A. Less than 2 years
   B. 2 years to less than 4 years
   C. 4 years to less than 6 years
   D. 6 years to less than 8 years
   E. 8 years or greater

3. Education (highest degree):

   A. LPN
   B. RN (Diploma)
   C. RN (ADN)
   D. RN (BSN)
   E. RN (MS)
   F. RN (PhD)

4. Length of time supervised by present head nurse:

   A. Less than 2 years
   B. 2 years to less than 4 years
   C. 4 years to less than 6 years
   D. 6 years to less than 8 years
   E. 8 years or greater

5. Average amount of time spent interacting with head nurse:

   A. Every day
   B. 3 to 4 times per week
   C. 1 to 2 times per week

6. Shift I usually work:

   A. 8-hour shift (days)
   B. 8-hour shift (evenings)
   C. 8-hour shift (nights)
   D. 12-hour shift (days)
   E. 12-hour shift (nights)

7. Do you work the Baylor Plan?

   A. Yes
   B. No

8. Are you a member of a professional nursing organization?

   A. Yes
   B. No (Please skip to Question 10.)

9. Which organizations do you belong to? (Circle all that apply.)

   A. ANA
   B. NLN
   C. AACN
   D. AORN
   E. ONS
   F. NAACOG
   G. Other (please specify): _____

10. What is your degree of involvement in professional activities? (Circle all that apply.)

   A. No involvement at this time
   B. Read publications of association
   C. Participate in functions of association
   D. Attend educational offerings or conventions
   E. Committee member of association committee
   F. Hold an elected position

11. Using the following definitions of formalization, rank the nursing unit according to the degree of formalization present in the organization.

   Formalization: The degree that rules are used by the organization to ensure continuity and consistency.

   High formalization: Rules are used to guide almost all decisions. The nursing unit operates using clearly specified rules and procedure manuals.

   Low formalization: Rules are used to determine decisions only when necessary. The nursing unit operates with few written rules and procedures.

   1 2 3 4 5

   (LOW) (HIGH)

12. Using the following definition of centralization, rank the nursing unit according to the degree of centralization that describes the nursing unit.

    Centralization: Administrative authority to make decisions about the people.

        High centralization: Administrative authority is concentrated in a few people.

        Low centralization: Administrative authority is shared among many people.

    1 2 3 4 5

    (LOW) (HIGH)

13. How do you like working for this institution?

    A. It's not a very good place to work, would change almost everything.
    B. It's all right, but there are many things that should be changed.
    C. It's a fairly good place, but quite a few things should be changed.
    D. It's a good place, but there are a few things that should be changed.
    E. It's a very good place, wouldn't change anything.

Thank you very much for your participation in this study!

APPENDIX E

INTERPERSONAL REACTIVITY INDEX

The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by circling the appropriate letter. When responding to an item, use the following code for the letter responses:

A = does not describe me well
B
C
D
E = describes me very well.

Read each item carefully before responding.

1.	I daydream and fantasize, with some regularity, about things that might happen to me.	A	B	C	D	E
2.	I sometimes find it difficult to see things from the "other guy's" point of view.	A	B	C	D	E
3.	I really get involved with the feelings of the characters in a novel.	A	B	C	D	E
4.	I am usually objective when I watch a movie or play, and I don't often get completely caught up in it.	A	B	C	D	E
5.	I try to look at everybody's side of a disagreement before I make a decision.	A	B	C	D	E
6.	I sometimes try to understand my colleagues better by imagining how things look from their perspective.	A	B	C	D	E
7.	Becoming extremely involved in a good book or movie is somewhat rare for me.	A	B	C	D	E
8.	If I'm sure I'm right about something, I don't waste much time listening to the other people's arguments.	A	B	C	D	E
9.	After seeing a play or movie, I have felt as though I were one of the characters.	A	B	C	D	E

10.	I believe that there are two sides to every question and try to look at them both.	A	B	C	D	E
11.	When I watch a good movie, I can very easily put myself in the place of a leading character.	A	B	C	D	E
12.	When I'm upset at someone, I usually try to "put myself in their shoes" for a while.	A	B	C	D	E
13.	When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me.	A	B	C	D	E
14.	Before criticizing somebody, I try to imagine how I would feel if I were in their place.	A	B	C	D	E

APPENDIX F

LEADER BEHAVIOR DESCRIPTION QUESTIONNAIRE-XII

LEADER BEHAVIOR DESCRIPTION QUESTIONNAIRE--FORM XII

Originated by staff members of
The Ohio State Leadership Research Studies
and revised by the
Bureau of Business Research

Purpose of the Questionnaire

On the following pages is a list of items that may be used to describe the behavior of your supervisor. Each item describes a specific kind of behavior, but does not ask you to judge whether the behavior is desirable or undesirable. Although some items may appear similar, they express differences that are important in the description of leadership. Each item should be considered as a separate description. This is not a test of ability or consistency in making answers. Its only purpose is to make it possible for you to describe, as accurately as you can, the behavior of your supervisor.

Note: The term "group," as employed in the following items, refers to a department, division, or other unit of organization that is supervised by the person being described.

The term "members" refers to all the people in the unit of organization that is supervised by the person being described.

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DIRECTIONS:

a. **READ** each item carefully.

b. **THINK** about how frequently the leader engages in the behavior described by the item.

c. **DECIDE** whether he/she is (A) always, (B) often, (C) occasionally, (D) seldom, or (E) never acts as described by the item.

d. **DRAW A CIRCLE** around one of the five letters (A B C D E) following the item to show the answer you have selected.

A = Always

B = Often

C = Occasionally

D = Seldom

E = Never

e. **MARK** your answers as shown in the examples below.

Example:	Often acts as described	A B C D E
Example:	Never acts as described	A B C D E
Example:	Occasionally acts as described	A B C D E

1.	Lets group members know what is expected of them.	A B C D E
2.	Is friendly and approachable.	A B C D E
3.	Encourages the use of uniform procedures.	A B C D E
4.	Does little things to make it pleasant to be a member of the group.	A B C D E
5.	Tries out his/her ideas in the group.	A B C D E

6.	Puts suggestions made by the group into operation.	A	B	C	D	E
7.	Makes his/her attitudes clear to the group.	A	B	C	D	E
8.	Treats all group members as his/her equal.	A	B	C	D	E
9.	Decides what shall be done and how it shall be done.	A	B	C	D	E
10.	Gives advance notice of changes.	A	B	C	D	E
11.	Assigns group members to particular tasks.	A	B	C	D	E
12.	Keeps to himself/ herself.	A	B	C	D	E
13.	Makes sure that his/her part in the group is Understood by the group members.	A	B	C	D	E
14.	Looks out for the personal welfare of group members.	A	B	C	D	E
15.	Schedules the work to be done.	A	B	C	D	E
16.	Is willing to make changes.	A	B	C	D	E
17.	Maintains definite standards of performance.	A	B	C	D	E
18.	Refuses to explain his/her actions.	A	B	C	D	E
19.	Asks that group members follow standard rules and regulations.	A	B	C	D	E
20.	Acts without consulting the group.	A	B	C	D	E

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