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Nursing leadership : a comparative study of self concept, leadership style and leadership effectiveness.

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NURSING LEADERSHIP: A COMPARATIVE STUDY OF SELF CONCEPT, LEADERSHIP STYLE AND LEADERSHIP EFFECTIVENESS

A Dissertation Presented

By

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Nursing Leadership: A Comparative
Study of Self Concept, Leadership Style
and Leadership Effectiveness
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ABSTRACT

The purpose of the study was to test certain assumptions about the relationships of leader self concept to the perceptions of self and others concerning the leadership style and effectiveness of designated leaders. Three general hypotheses were identified: 1) the greater the extent of positive self concept, the greater the congruence between one's own self perception of leadership style and effectiveness and the perception by others of the leader's leadership style and effectiveness; 2) the greater the congruence between the leader's self perception and the perception of the leader by others, the greater the effectiveness of the leader and 3) the greater the extent of positive self concept, the greater the perceived effectiveness of the leader. The general hypotheses were tested by specifying nine sub-

hypotheses. The sample was comprised of 22 Head Nurses, 157 Nursing Staff members and 7 Nursing Supervisors in two acute care, general hospital settings. By use of objective measures, scores were obtained for self concept (self report), leadership styles (Initiating Structure, Consideration, Task Behavior, Relationship Behavior) and Leadership Effectiveness (Overall Effectiveness, Planning Nursing Care, Supervision, Communication, Delegation). The results of the study tended to support the three general hypotheses. The results also indicated that, in general, Head Nurses had high self concepts but viewed their leadership styles oppositely on the two instruments used to measure leadership style. The Head Nurses' views of their own leadership style did not correlate with the views of their respective Nursing Staff. Although superiors and subordinates agreed on their effectiveness ratings of Head Nurses, the Head Nurse's self-perceived leadership style did not correlate with these effectiveness ratings. Finally, results indicated that if Head Nurses wish to be viewed as effective by superiors and subordinates, they should exhibit both Structure (Task) and Consideration (Relationship) behaviors to a high degree. Other findings, limitations, implications and suggestions for further research are discussed.

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to

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Jamie

and their Becoming

C H A P T E R I

INTRODUCTION

The major focus of the study was to identify the relationships among the self report of self concept, the leadership styles as perceived by self and by others and the leadership effectiveness as perceived by self and by others. The study was conducted with Head Nurses in two short term, general hospital settings.

The concept of leadership has received increasing emphasis in the field of nursing in recent years. Since 1961, when the earliest book on nursing leadership was published (Krohn, 1961), there have been books and articles appearing in the nursing literature that deal specifically with leadership in nursing (Davidson, 1968; Kramer, 1974; Krohn, 1961; Beyers & Phillips, 1971; Douglass & Bevis, 1974). Two themes recur in the nursing literature related to leadership in nursing. The first theme, a basic premise in nursing, is that <u>all</u> nurses, because they <u>are</u> nurses are leaders or managers. The second theme is that nurses are ineffective as leaders because they have not had the appropriate training and/or educational background to be leaders or managers (Christman, 1967; McBride, Diers & Slavinsky, 1972; Leininger, 1975; O'Donovan, 1975).

With nursing leadership receiving increased attention in the literature, different aspects of nursing have been studied by a variety of social-behavioral and management-administrative investigators. There have been few studies, however, directed toward identifying and analyzing leadership styles and effectiveness in nursing (Georgoupolos, 1975; Leininger, 1975).

Certain assumptions are evident in the literature about the relationships among self concept, perception of self as leader, and other's perceptions of the leader's style and effectiveness. The implications which can be drawn from this literature include the following. The first implication is that the more positive a leader's self concept, the more congruent the leader's view of his/her own leadership style and effectiveness will be with the views of the leader's subordinates and superiors. Secondly, it is implied that the closer the views of self as leader are to the views of others, the more effective the leader will be seen. The final implication is that there is a positive relationship between self concept and leadership effectiveness (Combs & Snygg, 1959; Fitts, 1971, 1972a, 1972b; Hersey & Blanchard, 1972, 1974; Wiley, 1974).

This study is, therefore, a field study to test the hypotheses that the above assumed relationships may be demonstrated in a sample of Head Nurses, Nursing Staff and Nursing Supervisors in two acute care, general hospital settings.

The remainder of this chapter will describe the rationale for the study. A statement of the problem and description of the purpose of the study will follow. The general hypotheses of the study will be included in this section. Certain terms pertinent to the study will be defined and the methods and procedures used in the study will be discussed briefly. The significance of the study and limitations will then be described. The chapter will conclude with a summary of the way in which the remainder of the dissertation will be organized.

Rationale for the Study

The study of complex organizations has received considerable attention from investigators during the past twenty years. Much of this research has occurred in health care settings, with most of the research focusing on the hospital as an organization and on the intraorganizational relationships within the hospital (Georgoupolos, 1975). The complexity and size of the health care industry is evident in the fact that it accounted for 7.7% of the Gross National Product during the fiscal year, 1974, with hospital care accounting for nearly 41 billion dollars, or 39.1% of the total spending of over 104 billion dollars (Costs of Health Care, 1975).

As an organization, the hospital is comprised of human and material resources contained in many different, but interlocking and interdependent parts. It is deliberately designed to accomplish its primary goal of providing quality

care and service to patients through the allocation of its resources and facilities and through the regulation of the efforts of the many staff members (Georgoupolos, 1966).

There are 857,000 registered nurses actively employed in the health care industry (Ratio of Nurse, 1975). Although nurses are finding employment in a wider variety of health care settings, hospitals continue to be the largest employer of registered nurses. The Head Nurse is seen as a leader within the organizational structure of the hospital who deals with both staff and with supervisors. The Staff are the Head Nurses' subordinates, the supervisors are superiors in the system. The Head Nurse, therefore, is the first level of leadership among nurses in the hospital system.

In perusing the literature on leadership in nursing, references to such topics as: "Characteristics of a good leader", "teaching-learning principles", "conferences", "change", "staff development", "evaluation of workers", and "making out assignments" are encountered. Documentation, where it does occur, rarely reflects literature in organizational theory and organizational behavior.

Leadership is defined in different ways by various authors of nursing books. Beyers and Phillips (1971), on one hand, define leadership as "organizing, activating, controlling and evaluating the performance of the work accomplished by the nursing staff on a nursing unit" (p. 17). On the other hand, Douglass and Bevis (1974) state that:

> Leadership, then is the ability to use the processes of life to facilitate the movement of a person, a group, a family, or a community toward the establishing and attainment of a goal. Nursing leadership is the ability to use the processes of life to facilitate the movement of a person, a group, a family, or a community toward the establishing and attainment of goals pertaining to health . . . the leadership role is an organized set of behaviors assigned to a position (p. 2, p. 5).

There is a lack of clarity in the definitions. According to McBride (McBride, et al, 1972), most nurses are educated to value the care and comforting aspects of nursing, with little concern for the type of leadership activities necessary to contribute to a more responsive and comprehensive system of health care delivery. Such activities and skills that would be related to change, organizational goals, design and effectiveness, decision-making and political strategies are not in the nurse's repertoire of behaviors. And yet, these changes in health care systems are dependent upon the quality of leadership of the practitioner, the educator and the researcher in nursing. McBride states, "Most nurses are neither interested in being leaders nor educated to be leaders" (p. 1445).

Diers (McBride, et al, 1972) describes nurses as lower in self esteem and initiative, with higher needs for submissiveness and structure than almost any other professional group. According to her, nurses are, therefore, hesitant to seek leadership positions and have difficulty in managing such responsibilities once leadership positions are taken. Diers

further describes what she calls a "shaky self concept" that reflects the confusion in nursing. The nursing bodies which educate and license nurses for practicing in the profession are uncertain as to what nursing is or how nursing contributes to the larger society. "If one begins with people with shaky self-concepts, adds an educational system guaranteed to train out qualities of independence and abstraction, graduates (them) into a profession largely underorganized and ambivalent about its worth, it is not surprising that leadership is a problem" (p. 1447).

As evident in the literature, the concern about the lack of leadership skills and abilities in nursing is directed toward leadership at the national level, the state level, the community level and the practitioner level. The expressed concern, the discrepancies and the misuses of terminology in the nursing literature contribute to the nurse's uncertainty and confusion in relation to leadership.

Although there have been a variety of studies in which nurses have participated as part of the sample group (Georgoupolos, 1975), certain areas of importance in nursing have not been studied. As Leininger (1974) states, "The effects of different organizational structures on nursing leadership and the effects of different leadership styles in relation to leadership effectiveness and retention have yet to be explored in research studies" (p. 33).

This study of leadership in nursing explores one of these identified areas which have so far been neglected in nursing leadership research: the areas so identified include (a) self concept, (b) leadership style as perceived by self and by others, and (c) leadership effectiveness as perceived by self and by others.

Statement of the Problem

Leadership has been described as a function of the leader, the follower and the situation by a number of authors (Adair, 1968; Barnard, 1948; Hersey & Blanchard, 1972; Tannenbaum & Massarik, 1957). Hersey and Blanchard (1974) further state that, "The closer and closer to reality a leader's perception is to the perceptions of others, i.e., subordinates, superior(s) and associates (peers) the higher the probability that the leader will be able to cope effectively with that reality" (p. 15). They also state that, "It is the perception, or the interpretation of reality, that affects one's actual behavior. In other words, reality is what a person perceives" (1972, p. 20). If the "reality" of a situation, as perceived by the leader and others, is congruent rather than discrepant, then the leader has a better chance to be effective in that situation.

The problem identified for this study then is one of determining the relationships among self concept, leadership styles as perceived by self and by others and leadership

effectiveness as perceived by self and by others. Because of the previously mentioned aspects of confusion about nursing leadership, and the lack of leadership in nursing, the problem identified for study will be applied to a group of Head Nurses, their subordinates and their superiors in two acute care, hospital settings. If the aspects of leader, followers, situation and perceptions are related positively to leadership style and effectiveness, it should be possible to demonstrate these relationships.

Purpose of the Study

The purpose of the study was to determine the relationships among the self report of self concept, leadership style and leadership effectiveness as viewed by Head Nurses; leadership style and leadership effectiveness as viewed by subordinates, and leadership effectiveness as viewed by superiors. These dimensions were measured by the Tennessee Self Concept Scale (TSCS), Leader Opinion Questionnaire-Ohio State Model (LOQ), Leader Behavior Description Questionnaire (LBDQ), Leader Effectiveness and Adaptability Description-Self (LEAD-Self), Leader Effectiveness and Adaptability Description-Other (LEAD-Other) and Leadership Effectiveness Rating Form (ERS).

Based on the theories relating to self concept, perception, leadership styles and leadership effectiveness, three general hypotheses were proposed for study.

I. The greater the extent of positive self concept, the greater the congruence between one's own self perception of leadership style and effectiveness and the perception by others of the leader's leadership style and effectiveness.

II. The greater the congruence between the leader's self perception and the perception of the leader by others, the greater the effectiveness of the leader.

III. The greater the extent of positive self concept, the greater the perceived effectiveness of the leader.

The general hypotheses were further specified into nine hypotheses. These hypotheses are identified in Chapter II.

Definition of Terms

To provide for clarity and ease in reading the study, the following defintions of terms, as used in this study, are provided.

Aide/Orderly: a paraprofessional worker in the hospital who has received on-the-job training in simple, basic, physical care measures and in non-complex procedures such as the taking of temperatures, and who works under the supervision of the registered nurse.

Consideration: the extent to which an individual is likely to have job relationships with subordinates characterized by mutual trust, respect for their ideas, consideration of their feelings, and a certain warmth between himself and them (Gibb, 1972, p. 1530).

Head Nurse: a Registered Nurse who has the responsibility to administer a particular nursing unit; including the co-ordination of patient care services, administration of nursing care, coordination of patient care activities and supervision of personnel on the nursing unit.

Initiating Structure: the extent to which an individual is likely to define and structure his/her own role and those of subordinates toward goal attainment. Characterized by an active role in directing group activities through planning, communicating information, scheduling, criticizing, trying out new ideas, etc., (Gibb, 1972, p. 1530).

Leadership Effectiveness: the ability of the leader to adapt his or her leadership style to meet the needs of the followers and the situation (Hersey & Blanchard, 1972).

Licensed Practical Nurse (LPN): a graduate of a school of practical nursing who is qualified, by a state licensing examination, to provide nursing care to patients in non-complex nursing situations; is under the supervision of a registered nurse or physician.

Nursing Supervisor: a Registered Nurse who is the immediate superior of several Head Nurses in a hospital; who

assists with interdepartmental communication and with problems of administration of nursing care, coordination of patient activities and supervision of personnel; and who provides the direct link between the Head Nurse and the Director of Nursing Service.

Nursing Staff: the employees assigned to a particular nursing unit including Registered Nurses, Licensed Practical Nurses, Aides and Orderlies; but excluding the Head Nurse and Nursing Supervisor.

Relationship Behavior: the extent to which a leader is likely to maintain personal relationships between himself and members of his group by opening up channels of communication, delegating responsibility, giving subordinates an opportunity to use their potential; characterized by socioemotional support, friendship, and mutual trust (Hersey & Blanchard, 1972, p. 83).

Registered Nurse: a graduate of an approved school of professional nursing who is qualified by a state licensing examination to plan, provide and evaluate nursing care to patients in a variety of health care settings; who may be a graduate of a three year, hospital based diploma program, of a two year associate degree program in a community college or of four to five year baccalaureate degree programs in colleges or universities; and who has both dependent and independent functions.

Task Behavior: the extent to which a leader is likely to organize and define the roles of the members of his group; to explain what activities each is to do and when, where, and how tasks are to be accomplished; trying to establish well-defined patterns of organization, channels of communication, and ways of getting jobs accomplished (Hersey & Blanchard, 1972, pp. 82-83).

Methodology

A brief description of the methods and procedures used in the study are included here. A more detailed examination of the methodology may be found in Chapter III.

The sample for the study was comprised of Head Nurses, Nursing Staff and Nursing Supervisors from Cooley Dickinson Hospital (Agency A) and Wesson Memorial Hospital (Agency B). Both hospitals are general, acute care health delivery systems.

In Agency A, the sample employed in the study consisted of 10 Head Nurses, 62 Nursing Staff members working under the direction of the Head Nurses and 3 Nursing Supervisors. The sample from Agency B included 12 Head Nurses, 95 members of the Nursing Staff and 4 Nursing Supervisors. The total population in the sample was 22 Head Nurses, 157 Nursing Staff members and 7 Nursing Supervisors.

All of the Head Nurses, Registered Nurses, Licensed Practical Nurses and Nursing Supervisors were female. The Head Nurses and Nursing Supervisors in both agencies were graduates of diploma nursing programs.

Data were obtained by having each Head Nurse complete the Tennessee Self Concept Scale, the Leader Opinion Questionnaire-Ohio State Model and the Leader Effectiveness and Adaptability Description-Self instruments. These instruments provided scores of self report of self concept and self perceived leadership style and effectiveness.

To obtain data about the Head Nurse's leadership style and effectiveness as perceived by others, subordinates of each Head Nurse completed a Leader Behavior Description Questionnaire, a Leader Effectiveness and Adaptability Description-Other and a Leadership Effectiveness Rating Form.

Further data of the Head Nurses' effectiveness, as perceived by superiors, were obtained by having the Nursing Supervisors complete Leadership Effectiveness Rating Forms for those Head Nurses for whom the supervisor assumed primary or secondary responsibility.

The data obtained from the Leader Behavior Description Questionnaire were subjected to analysis of variance in order to compare the leadership scores within the Head Nurse sample and the leadership scores across the Head Nurse sample. An **F** test result greater than 1 was accepted as indicating a greater variation between the Head Nurses' leadership scores than within the Head Nurses' leadership scores. The results of the analysis of variance demonstrated that the LBDQ instrument reliably described the leader behavior of the Head Nurses in

the sample (Kerlinger, 1973).

Pearson product moment correlations were computed between the Head Nurse's total self concept score and the congruency between the leadership style scores as perceived by self and others. Pearson correlations were also computed between the effectiveness scores of subordinates and supervisors.

Congruency was determined by computation of discrepancy scores in order to determine the extent to which the Head Nurse's self concept score correlated with the difference between the Head Nurse's self perceived scores on the LOQ and LEAD-Self and the mean scores of subordinates on the LBDQ and LEAD-Other, respectively.

Significance of the Study

The major importance of the problem under study was to test certain assumptions about the relationship of leader self concept to the perceptions of self and others concerning his or her leadership style and effectiveness. These assumptions are prevalent in behavioral science and organizational behavior literature and include the following:

1. The self concept is of extreme importance in determining behavior (Combs & Snygg, 1959; Fitts, 1971, 1972a, 1972b; Wiley, 1974).

2. An individual's perceptions influence his or her behavior, and those perceptions <u>are</u> reality for the individual at the moment of behaving (Combs & Snygg, 1959; Hersey & Blanchard, 1974).

3. The perception the leader has of his or her leadership style is less important than the perception that others have of his or her leadership style (Hersey & Blanchard, 1972).

4. Leadership effectiveness is the ability of the leader to adapt his or her leadership style to meet the needs of the followers and the needs of the situation. This effectiveness depends on the perceptions of the followers (Barnard, 1948; Hersey & Blanchard, 1972; Hollander & Julian, 1969; Tannenbaum & Massarik, 1957).

Certain suppositions about human behavior are inherent in the above comments about leadership perception and self-perception. First, there are assumptions that leadership style and leadership effectiveness are influenced by the perceptions of others. Secondly, there is an assumption that the effective leaders' self concept and self perceptions of leadership style is positively related to the perceptions of others. A final assumption is that the more positive the self concept of the leader, the more congruent will be the leader's and follower's perceptions of leadership/style and effectiveness.

If one accepts the assumptions underlying the implied relationships among self concept, leadership style as perceived by self and by others and leadership effectiveness as perceived by self and by others, then it should by possible to document, through study, such significant relationships.

Limitations of the Study

Several limitations are evident as a result of the nature of the study design itself. Further discussion of the limitations of the study will be provided in Chapter V.

First, validity is a major concern in any test to measure self concept. It must be considered an important variable in the interpretation of the results of this study (Crandall, 1973).

Second, a major issue in self-theory revolves around the distinction made between inferred self concept and self report of self concept. Because the Tennessee Self Concept Scale provides a measure of self report of self concept, there will be limitations on the interpretation of the results (Combs & Soper, 1957, 1963; Combs & Snygg, 1959).

Third, neither the Leader Effectiveness and Adaptability Description-Self nor the Leader Effectiveness and Adaptability Description-Other have undergone studies for reliability. The instruments appear to have face validity, but no other studies of validity have been done for either instrument (Blanchard, 1975). This will make interpretation of the results difficult.

Organiztion of the Remainder of the Dissertation

Chapter II provides a selective review of the literature as it relates to the theory of self concept, the theories around leadership style and leadership effectiveness as per-

ceived by self and others, and studies of leadership in nursing. A statement of the hypotheses concludes the chapter.

Chapter III provides a detailed description of the research design, methodology and procedures used in the study.

Chapter IV presents the results of the study in statistical form. The results of the study are discussed.

Chapter V considers the results of the study in terms of implications, limitations and suggestions for further research.

C H A P T E R I I

SELECTIVE REVIEW OF THE LITERATURE AND STATEMENT OF HYPOTHESES

Introduction

This chapter is intended to provide a selective review of the literature pertaining to the problem being studied. The literature review will include the theory of self-concept and the theories of leadership styles and effectiveness including the ramifications of perception of leadership by oneself as well as others. Additional studies, related to leadership in nursing will be reviewed. The chapter concludes with the statement of the general and specific hypotheses of the study.

Self Concept Theory

Edgar Schein (1965) has described four dimensions of the nature of man. The first, rational-economic man, describes man as unpredictable and passive with highly irrational feelings which must be controlled by those in authority positions. Rational-economic man is motivated by self interests and economic incentives. Organizations predicated on this belief of man focused, primarily, on meeting only the most basic needs of man, as described by Abraham Maslow--the physiological and safety needs.

As society, technology and organizations became more complex, a second set of assumptions about the nature of man evolved--social man. These assumptions stressed that man needed more from his work than just the satisfaction of his basic needs. Man, in fact, looked to work to meet his social needs for belonging. Social man's identity is based on his relationships with his fellow workers, and peers exert more force on him to change than does management. The recognition of the informal group within the formal organization occured in this view of man. Man was a member of two work-related groups, one formal and the other informal; with the informal group having the potential for either positive or negative impact on its members. The impact on the formal organization could also be positive or negative. The Human Relations school of management thought resulted, with management styles directed at being considerate of employees.

A third set of assumptions of man have evolved from the concept of man as a socially-motivated individual to the concept of man as a self-actualizing being. These assumptions describe man as internally motivated to use his capacities and skills to obtain meaning and satisfaction in his work. McGregor's Theory Y (1960) description of man is consistent with this view of man as self-actualizing. Management styles

reflected this view by looking at ways to make the employee's work more challenging and meaningful, in order to meet the higher order of needs as described by Maslow (1954)--the esteem and self-actualizing needs.

These three sets of assumptions about the nature of man have been in part accurate, but the fourth set of assumptions has gone beyond this to describe man as complex man. Complex man is a biological, psychological and social being interacting with himself and his environment. He is a being with many needs, motives and potentials--some of which make him similar to other beings and others which make him unique. Complex man may be viewed as one whose needs and motives vary from time to time and place to place. Complex man is adaptable, flexible and capable of learning. He is capable of becoming all of which he is capable of becoming.

This view of complex man is further demonstrated in the theories of Maslow (1970), Combs and Snygg (1959) and Rogers (1961). Maslow stresses a hierarchy of needs with an emphasis on the highest level of need which is termed "self-actualization." Self-actualization refers to the development of full individuality, with all parts of the personality in harmony with each other. For Maslow, the self actualized person is someone who makes extraordinary use of his full potential.

Although few persons ever achieve self actualization, all have the need and the potential to grow and change in positive ways. Maslow identifies that many people experience transient moments of self actualization which he calls peak experiences. During such experiences, the individual senses a feeling of non-striving, wholeness, and aliveness; an experience which carries its own intrinsic value with it.

Self actualizers have certain characteristics. They perceive reality efficiently and are able to tolerate uncertainty and ambiguity. They are able to accept themselves and others for what they are and are able to view life objectively. Self actualizers have more peak experiences, greater appreciation of life and rich emotional reactions. They are spontaneous in thought and action and are highly creative (Maslow, 1970, p. 26).

The concept of self actualization implies a dynamic and active process throughout one's life. It is not a static concept or an ultimate goal in one's life, rather, the pressure to achieve self actualization is occuring all of the time in an individual's life. One can increase his potential for achieving self actualization by trying new things, by being fully absorbed in what is being experienced, and by being sensitive to one's own feelings and reactions (Maslow, 1970).

Combs and Snygg delineate man's basic need as a need for "adequacy" which is expressed in man's behavior at every instance of his existence. This need serves as a driving force for each individual as he constantly seeks ways to make himself ever more adequate to cope with living (p. 46). The degree to which this adequate functioning is achieved is largely dependent upon the individual's perceptual field which is defined as "the entire universe, including himself, as it is experienced by the individual at the instant of action" (p. 20). Combs and Snygg state further that, "all behavior, without exception, is completely determined by, and pertinent to, the perceptual field of the behaving organism" (p. 21). The authors identify the "phenomenal self" as the self of which the individual is aware. It is the self as observed, experienced and judged by the individual-his self concept. "To the degree that one's self-concept is 'realistic', he is said to have 'insight' into himself" (Wylie, 1974, p. 5).

The concept of self, according to Soares and Soares (1973), is derived in the following manner. First, it is derived from the responses made toward an individual by significant others in his immediate environment. This is followed by the individual's perceptions of their behavior

to him, by the internalization of his perceptions of their behavior and by the resultant self he perceives as reflected back into the eyes of the significant others. Then the self, as seen by the individual, is reinforced by others and by his view of their concepts of him. Finally, the self is derived from the individual's responses to the challenges and pressure of living.

Rogers (1961) characterizes man as a potentially "fully functioning" individual with certain attributes; such as, positive regard of self, openness to experiences, capable of self-regulation and self-direction, one who is in a continuing process of increasing awareness and functioning. Implicit in this is a basic belief that man has both the motivation and the ability to change.

The "self" is the most important concept in Rogers' theory. The self is comprised of all of the ideas, perceptions and values which characterize the "I" or "Me", and the perceptions of the relationships of the "I" or "Me" to others. The self concept influences the person's perception of the world as well as his behavior in that world, although the self concept does not necessarily reflect reality. For example, a person may be highly regarded or respected in his profession and yet view himself as a failure.

The self concept is learned through one's experiences which are used to form impressions and attitudes about one's "self". Every experience is evaluated in terms of one's self concept, then, with a person striving to behave in ways which are consistent with his self image. Since new experiences are interpreted in light of all the beliefs and attitudes from prior experiences, and if the new experience is consistent with one's self concept, it will be incorporated into the self concept. If the new experience is not consistent with one's view of self, it will be denied or ignored. Rogers refers to a state in which the experiences are accurately "symbolized" (or integrated and genuine) into the self concept as a state of congruence. New experiences which threaten an individual's self concept remain "un-symbolized" (or non-integrated) with the self. A discrepancy exists between the perceived self and the actual experience creating conflict and tension for the individual. This discrepancy is referred to as incongruence by Rogers, and leads to incongruence in behavior (Rogers, 1951, 1961).

The "ideal self" is also important in Rogers' theory. This is the concept one has of the kind of person he would like to be. The closer the ideal self to the real self, the more fulfilled will be the person. The ideal self may be congruent with the self concept or it may result in

incongruence if there is a large discrepancy. It is possible, therefore, for an individual to experience incongruence either between his perceived self and the experiences of reality or between the perceived self and the ideal self (Rogers, 1951, 1961).

Rogers describes the development of the need for positive regard in an individual as being dependent upon others' experiences. This need is universal because all people want to be accepted and loved by others. The individual's positive regard is satisfied when he perceives himself as satisfying another's need (Patterson, 1973; Rogers, 1961).

The need for self-regard develops later and is the internalization of those actions and values which significant others approve. Self regard develops by having significant others distinguish the self experiences of the individual as being more or less worthy of positive regard. This evaluation of one's self experiences by others constitutes a condition of worth. If one received unconditional positive regard, there would be no development of conditions of worth in the individual, rather, there would be congruence between his self concept and his actual experiences, as well as between his self concept and ideal self (Patterson, 1973, Rogers, 1961).

Finally, Rogers (1961) stresses a tendency, and

capacity in every individual, to move toward expressing all the capacities of the individual-"to expand, extend, become autonomous, develop, mature" (p. 35). It is a basic force motivating the individual toward self-actualization and contributes to the individual's capacity to change and to reorganize his concept of himself thus being able to "cope with life more constructively, more intelligently, and in a more socialized as well as a more satisfying way" (1961, p. 36). The individual moves toward a concept of himself as a person of worth, a person who is more open to his experience and is more self confident and self directing. Such an individual becomes more realistic in his perceptions and more accepting in his attitudes towards others. There is more congruence between the self concept and the ideal self.

The preceding descriptions of man, as a total and complex being, characterize the total self, as experienced by the individual. The descriptions share a common emphasis on man's potential for self-direction and freedom of choice. They are concerned with man's perception of himself, his immediate experiences and his personal view of the world which are involved, complex and significant factors in his behavior. The descriptions stress the positive nature of man's striving toward growth and self actualization. Man

has a basic need to develop his potential to the fullest, that is, to move forward and to change positively from what he is now.

Several authors have stressed the fact that the self concept is important in work relationships. Fitts (1972) states that the more optimal the self concept, the more effective will be an individual's performance. He also sees one's self concept as being a significant factor in the choice of a vocation, and in predicting one's performance in work settings.

Combs and Snygg (1959) describe man's perceptions as being meaningful to him and as helping to maintain the organization of his perceptual field and thus to satisfy the basic need for adequacy. The more closely related an experience is to the self, the greater will be its effect on behavior. Combs and Snygg quote Harry Stack Sullivan as saying, "if there is a valid and real attitude toward the self, that attitude will be manifest as valid and real toward others" (p. 151). There are implications for every aspect of human behavior in this, for "people behave in terms of the self concepts they possess, and this fact is tremendously important to anyone who must work with people in any capacity whatever" (Combs & Snygg, 1959, p. 151).

A major issue in self-theory is the distinction made between the inferred self concept and the self report of

self concept. Combs et al. (1959, 1963, 1971) stress the fact that self concept and self report are different concepts and are not interchangeable terms. The self concept is what an individual believes about himself and it is not open to direct observation. It can be inferred by observing behavior and then inferring the nature of the self perceptions which produced the behavior. The inferred self concept does not have a perfect relationship with the self concept, either (Combs & Snygg, 1963, p. 495). The self report represents what the individual says he is to an outsider. Combs et al. (1963, p. 494) state that, "the self report will rarely, if ever be identical with the self concept." To document this position, Combs et al. (1963) studied 59 sixth grade children and found an average correlation of .11, or no significant relationship, between the childrens' self reports and the inferred self concepts made by trained observers.

Fitts (1971) and Wylie (1974) also differentiate between inferred self concept and self report. Fitts believes, however, that the differences does not mean that investigation should abandon all instruments of measurement of self report. According to Fitts, each person is constantly revealing his self concept through his behavior and self report provides a simple and direct way of obtaining at least a sample of one's self concept (p. 39). Combs et al.

(1971) also state that the self report does have value since it provides observable behavior of what a person has to say about himself. "Like any other behavior, it is an expression of the subject's perceptual field at the moment of acting. ...It has more than ordinary value for helping us understand another person" (p. 54).

The most frequently utilized methods for measuring self concept are self report methods, observational methods or some combination of the two. It is clear, however, that there are difficulties in trying to measure subjective experiences of individuals. In order to understand behavior, one needs not only to identify the external situation, but also to identify how the situation looks to the individual. Thus, to scientifically study an individual's experiences, objective measures of subjective experiences are needed.

Self and Other Perception of Leadership Style and Effectiveness

Perception of self and others plays an important part in influencing behavior. One's ability to perceive accurately is subject to distortions, stereotyping, "halo effect", projection and perceptual defenses that distort one's perceptions to defend against having to change one's stereotypes. Our perceptions depend in large part on

attitudes and values we bring to any particular experience. According to Cantril (1957), meanings we attach to things, people and events are meanings and significances that are built upon past experiences. Since they are built up through past experiences, they are not inherent or intrinsic in the "stimulus" of the experience itself.

Behavior (Rogers, 1951) is seen as being determined by the perceptions of the experience by the individual rather than by the direct influence of the experience, itself. The behavior resulting is not to reality, but to the perception of reality. Since the only individual who could fully know his phenomenal field is the individual himself, his behavior might be best understood by turning one's attention to studying the world as viewed by the individual. To gain an understanding of the internal frame of reference of the person himself, one must see the world through his eyes.

Zalkind and Costello (1962) list four conclusions they believe to be suggested by research in the field of perception. The four conclusions include:

1. Knowing oneself makes it easier to see others accurately.
2. One's own characteristics affect the characteristics one is likely to see in others.

3. The person who accepts himself is more likely to see favorable aspects of other people.
4. Accuracy in perceiving others is not a single skill (p. 226).

Rogers (1951, 1961) believes that the individual has the capacity to reorganize his field of perception, including the way he perceives himself. There is a close relationship between an individual's behavior and the way that reality is viewed by the individual. Therefore, an individual has an appropriate behavior change when he acquires a different view of his experiential world, including himself. This changed perception doesn't need to be dependent on changes in "reality"...it may be the product of internal reorganization for the individual.

Bem's (1970) theory of self-perception, although an attempt to provide a theoretical framework for the process of attitude change, is related to the theory of self concept. The major hypothesis of the self-perception theory states that, "In identifying his own internal states, an individual partially relies on the same external cues that others use when they infer his internal states" (p. 50). One is able to identify his own internal states because others have inferred and labeled those internal states by observing the behavior. Since one observes how someone acts in order to know what that person is feeling,

one can infer one's own inner state and feelings by observing one's own overt behavior. Bem's (1970) self perception theory postulates that weak or ambiguous internal cues force an individual into a position of objective, outside, observer. In observing one's own behavior and the situation surrounding it, one is able to decide what the feelings are, and provide a base for beliefs and attitudes. Changing one's behavior will also change beliefs and attitudes which affect one's self-knowledge or changes one's self perception. Bem's theory of self perception is consistent with the ideas of self-actualization, change and reorganization previously described.

When all of the perceptions of the qualities, abilities, impulses, and attitudes of the person (all of the ways in which the individual perceives himself), and all of the perceptions of the self in relation to others are accepted into the organized conscious concept of the self, then the individual's achievement is accompanied by feelings of comfort and freedom from tension. This is experienced as psychological adjustment (Patterson, 1973, Rogers, 1954, 1961).

Each individual brings into a work setting his own psychological, social and economic wants, and these contribute to his perceptual accuracy. Individuals affect and are affected by each other. Individuals are responding to stimuli in the situation which contributes to their perceptual fields. That discrepancies should occur between

perceptions of leaders and followers in organizations, then, is not surprising. Likert (1961) indicates that discrepancies occur because of the difference between what leaders say they do and their actual behavior. In addition, there are differences in perceptions by different employees as to the behavior of a superior, due to the employee's unique background and previous experiences. This discrepancy is also identified by Scott (1956) as generalizations which have occurred from studies of social perception. He stresses, first, that what a person perceives, when confronted with a stimulus situation may not correspond to "objective reality." Secondly, when several individuals are confronted with the same situation, they may perceive the situation differently. Third, certain biological, psychological, social and cultural factors will influence the way in which an individual perceives a situation. Finally, the individual will respond to his environment in terms of his perceptions of that environment.

A person's self concept, then, is a powerful influence on one's behavior. It is comprised of all of one's beliefs about oneself, the strengths and limitations and the potential for growth and change.

As the self-concept determines one's behavior, it is also open to the influence of the views of others about the individual. As Jourard (1974) states, "other people define

us to ourselves, if we listen to them" (p. 153), thus confirming one's self concept favorably or unfavorably. One then acts to persuade others to view oneself in the way one has come to believe oneself to be, because of the view of others.

Leadership Styles and Effectiveness

Leadership is generally defined as the behavior of one member of a group toward another member, or members, of the group which is directed toward accomplishing some goal. Leadership, therefore, is interpersonal by nature and requires two or more people in order for the term to have any meaning.

Early studies of leadership focused first on the leader himself, and attempted to describe characteristic traits of leaders. Studies then moved to the situation where the characteristics of the leader depended on the situation he was in. Next, the follower, and his needs and wants were stressed in leadership studies (Gouldner, 1965; Hollander & Julian, 1969; Tannenbaum & Massarik, 1957). Leadership, widely studied by a variety of researchers, has two dominant areas of concern. One area is related to goal achievement functions, also known as initiating structure or Task Behavior. The other area is related to group maintenance functions, also known as consideration or Relationship Behavior.

If leader, followers and situation are important and interacting aspects of leadership, then one must ask how the perceptions of leader and followers relate in a particular situation. There are a number of studies reported, often resulting in inconsistent or unrelated findings.

Stogdill and Shartle (1955) report that correlations between self description and descriptions of others on the Leader Behavior Description Questionnaire show that they are not in agreement. Findings of similar discrepancies between superiors and leader or leader and followers have been demonstrated by Evans (1973), Distefano and Pryer (1973) and Templer (1973).

Other aspects of leadership studies have indicated that a more supportive management style (Relationship Behavior) resulted in more job satisfaction for employees while a higher degree of favorableness of self perceptions was associated with lower job satisfaction for employees (Thompson, 1971). Denmark (1973) reported that there was a positive relationship between leadership effectiveness and self acceptance (an element considered to be a part of one's self-concept) in a study of 4H adult leaders in 25 counties in a southern state.

According to Hersey and Blanchard, (1972) it is important to differentiate between management and leadership.

Management is "working with and through individuals and groups to accomplish organizational goals" (p. 3); whereas leadership, a broader term, is "the process of influencing the activities of an individual or a group in efforts toward goal achievement in a given situation" (p. 68). The key difference between the two definitions is the word "organizational" found in the definition of management but missing from the definition of leadership. It is possible that the goals of the leader and the goals of the organization may be in opposition to each other. As Litterer (1973) states, leadership then "involves (1) leaders and followers, (2) getting something done, (3) in a particular situation" (p. 168).

Hersey and Blanchard (1972) have developed a theory of leadership entitled Life Cycle Theory of Leadership. The Life Cycle Theory of Leadership is an outgrowth of the Tri-Dimensional Leader Effectiveness Model originating at Ohio State University. It is "based on a curvilinear relationship between task behavior and relationships behavior and maturity", and on an understanding of the relationship between leadership effectiveness and the maturity level of followers (Hersey and Blanchard, 1972, p. 134). An effective leader is one who is able to adapt his leadership style to the

maturity level and needs of his followers.

In order to utilize the Life Cycle Theory of Leadership, one has to understand certain prerequisite concepts to the Theory. These concepts include: Successful Leadership, Effective Leadership, Task Behavior, Relationship Behavior, Maturity-Immaturity, Tri-Dimensional Theory of Leadership and Adaptability, and Motivation-Hygiene.

Successful leadership occurs when a leader exerts influence over another by reason of his position in the organization--his position power. The focus is on the output that occurs. The leader will be considered successful to the degree that the follower accomplishes the job. The emphasis is on production (Hersey and Blanchard, 1972, pp. 92-95).

Effective leadership occurs when a leader exerts influence over another by reason of his personal power, that is, power received from his followers. The focus is on the "internal state" of the followers and because it is attitudinal in nature, it reflects that the followers own personal goals are being met or are consistent with the leader's request (Hersey and Blanchard, 1972, pp. 92-95).

It is possible for a leader to be successful and effective if he has both position power and personal power. In fact, if a leader is effective, he will of necessity be

successful. It is also possible for a leader to be successful but ineffective, if he has only position power. Productivity occurs, the work gets done, but the followers' goals are ignored or are inconsistent with the productivity goals.

An individual's leadership style consists of his patterns of behavior when he is involved in directing the activities of others. The style consists of task behavior or relationships behavior or a combination of both task and relationship behavior.

Task Behavior is defined as:

> The extent to which a leader is likely to organize and define the roles of the members of his group (followers); to explain what activities each is to do and when, where, and how tasks are to be accomplished: characterized by endeavoring to establish well-defined patterns of organization, channels of communication, and ways of getting jobs accomplished. (Hersey & Blanchard, 1972, pp. 82-84).

Relationship Behavior is defined as:

> The extent to which a leader is likely to maintain personal relationships between himself and the members of his group (followers) by opening up channels of communication, delegating responsibility, giving subordinates an opportunity to use their potential: characterized by socioemotional support, friendship, and mutual trust. (Hersey & Blanchard, 1972, p. 83).

There are four basic leadership behavior styles, then, that are observable in leaders. An individual may exhibit High Task/Low Relationship Behavior (HT, LR); High Task/ High Relationship Behavior (HT, HR); High Relationship/Low

Task Behavior (HR, LT); or Low Relationship/Low Task Behavior (LR, LT).

The Tri-Dimensional Theory of Leadership and Adaptability model adds the dimension of effectiveness to the other two dimensions of Task Behavior and Relationship Behavior. This allows that a variety of leadership behavior styles will be effective or ineffective depending on the situational demands of a specific environment. Any of the four leadership behavior styles will be effective, then, if appropriate to a given situation. If the leadership style is not appropriate to a given situation, the style is ineffective. Since there is no one best style of leadership that can be used in every situation, it becomes important for a leader to know:

1. What his dominant leadership behavior style is.
2. What his supporting leadership behavior style is.
3. What his style adaptability is--i.e., the range of behaviors he has with which to vary his leadership behavior style.

"Adaptive leaders have the potential to be effective in a number of situations" (Hersey & Blanchard, 1972, p. 121).

Maturity, as used in the Life Cycle Theory of Leadership, includes three behavioral characteristics:

1. Achievement motivation.
2. Willingness and Ability to assume responsibility.
3. Task relevant education and experience.

Maturity, as thus defined, contains elements of three different theories. It includes McClelland's theory on Achievement Motivation, Argyris' theory about Maturity-Immaturity and Herzberg's theory on Motivation-Hygiene.

According to McClelland, individuals with a high need for achievement set moderately difficult but achievable goals for themselves. They take moderate risks because they can influence the outcome. Achievement-motivated people are more concerned with personal achievement than they are with material rewards or praise and will seek situations where concrete feedback on the nature of their work and on how well they are doing is received (Hersey & Blanchard, 1972, pp. 35-37).

The Immaturity-Maturity Theory of Argyris describes seven changes in characteristics that occur as man develops from immaturity to maturity. He moves from passivity to activity; from dependence on others to independence; from a limited way of behaving to a wide range of behaviors; from superficial, limited interests to deeper and stronger interests; from short time perspective on the present to a long time perspective, including past and future; from a subordinate position to an equal or superordinate position; and from a lack of awareness of self to self-awareness and self-control. Argyris contends that it is human nature to move toward maturity, but that organizational sys-

tems treat the workers as through they were immature (Hersey & Blanchard, 1972, pp. 50-53). When an individual is consistently treated as immature, he eventually will behave immaturely, i.e., passive, dependent, here-and-now focused, etc., or he will leave the situation.

Herzberg's Motivation-Hygiene Theory is based on research that identified two different sets of needs related to job satisfaction or dissatisfaction. Herzberg found a group of needs that were concerned with the environment and which prevented job dissatisfaction. These were called Hygiene factors and included: company policies and administration, supervision, working conditions, interpersonal relations, money, status, and security. Hygiene factors prevent job dissatisfaction but do not produce job satisfaction. Motivators, on the other hand, have to do with the work itself and how people feel about their jobs. Motivators included: feelings of achievement, recognition for accomplishment, challenging work, increased responsibility, and professional growth and development. Motivators are responsible for feelings of job satisfaction and have a positive effect on motivating workers to a higher level of performance.

Maturity, as used in the Life Cycle Theory of Leadership, therefore, consists of Achievement Motivation,

Maturity elements and Motivators as previously described by McClelland, Argyris and Herzberg, respectively.

Leadership Studies in Nursing

During the past 15 years, there have been several books published and journal articles have appeared reflecting an interest in nursing leadership. These publications express a basic premise that all nurses, because they are nurses are leaders. Actual study of nurses as designated leaders, such as the Head Nurse, or as leaders in general seems to be quite limited. The following reports of studies indicate the scope of some studies of nursing and leadership. The first three relate to characteristics of nurses.

Kelly (1974), in studying nurses, who were and who were not promoted, utilized four psychological measurements to identify traits that could be used to predict "leadership in nursing." The Minnesota Multiphasic Personality Inventory (MMPI), the Sixteen Factor Personality Questionnaire (16PF), the California Psychological Inventory (CPI), and the Edwards Personal Preference Schedule (EPPS) were administered to 545 Registered Nurses, of whom 120 were selected for evaluation for promotion. Of this number 42 Registered Nurses were promoted. Kelly found three decisive traits that significantly differentiated the nurses

promoted from those not promoted. He described the traits as capacity for status, femininity and relaxed demeanor. The first trait, capacity for status, was based on the Test-taking attitude variable on the MMPI. The second, femininity, also came from the MMPI-The Masculinity-femininity variable. The third trait, relaxed demeanor, was based on the Subduedness vs. Independent variable on the 16PF. The nurses who were promoted could be described as seeking increased status while remaining feminine and subdued in behavior. The trait of desire for status seems to be in conflict with the nurses' trait of subduedness.

In a study reported by Coleman and Glofka (1969) on the impact of group therapy on the positive growth of self concept, the Tennessee Self Concept Scale was administered as a pre-test and post-test on a control group of 30 members and an experimental group of 27 members. The groups were comprised of senior students in nursing who were experiencing their psychiatric nursing affiliation in a 12 week period of time. The experimental group participated in weekly group therapy sessions led by psychologists. At the end of 10 weeks, the experimental group showed significant positive growth of the self concept as measured by the TSCS, for Total Positive Score and on six of the 14 sections of the scale.

In another study (Corrigan & Julian, 1966) concerned with the identification of characteristics of Registered

Nurses who were promoted or not promoted, the authors found that applicants for the position of Head Nurse reflected characteristics more compatable with the need to control, rather than to nurture. The applicants had an ideal Head Nurse stereotype that characterized Head Nurses as executive rather than maternal in nature.

A part of this study involved administering the MMPI to all Registered Nurses at the agency. The three groups (applicants, those promoted, older Head Nurse group) did not differ significantly on their profiles on the MMPI. The homogeneous profiles suggested certain group tendencies for the nurse which included: defensiveness, sensitivity to criticism, cautiousness, conformity, rigidity, power orientation, emotional coldness, reliance on external structure and emotional constriction. Nursing, as a helping profession, has been able to be controlling of others for the "good" of the patient. Corrigan and Julian place hope for change on the new graduates from nursing programs, whom they see as having greater independence and outgoingness than did those nurses in their study. The results of this study tend to support the view in the nursing literature of Christman (1967), and McBride, Diers and Slavinsky (1972), which hold that nurses are psychologically and educationally unsuited to be leaders even though they are in leadership positions in health care systems.

Next, three studies related to Initiating Structure and Consideration dimensions will be discussed. Szilagyi and Sims (1974) report that the Consideration and Structure measure obtained from administering Fleishman's Supervisory Behavior Description Questionnaire were stable across time, sex differences, types of organization, culture and analysis technique when compared with previous leader behavior studies. The sample of 1,161 employees of a medical center was predominantly female (79.6%). Instruments that have been developed to measure leader behaviors of Consideration and Structure do produce stable scores, tending to support reliability of the instruments. This stableness of scores was demonstrated in a predominantly female population. The present study carried out by the investigator, is concerned with the two leadership behaviors of Consideration and Structure as perceived by Head Nurses and staff. It is also a study that is comprised of a predominantly female (98%) population.

Oaklander and Fleishman (1964), using two questionnaires studied the relationship between formal leadership characteristics and organizational stress. One questionnaire measured leadership and the other measured intra-and interdepartmental stress in one governmental and two voluntary general hospitals. Their findings indicate that role perceptions of the supervisors (44 Nursing Supervisors) was related to the amount of both internal and interdepartmental

stress. They also found that the higher the Consideration dimension, the more positive the relationship to lower internal stress in both kinds of hospitals. In no instance was the higher Consideration score related to interdepartmental stress. Finally, they found a less consistent relationship between the Initiating structure scores and stress, pointing out the influence of situational differences on the effects of leadership.

Rim (1965), in exploring risk taking behaviors on committees found support for the hypothesis that leadership attitudes of Consideration and Structure affect the "risky shift" phenomenon in decision-making. It was found that Head Nurses who scored higher on Structure tended to take higher initial risks in a committee structure. However, those who were high on both Consideration and Structure were most likely to be the influencers of the group.

There have been a few studies, reported, which attempt to relate task and relationship orientations to job satisfaction or work group performance. Evans (cited in Georgopoulos, 1975) examined employee job satisfaction and job performance as consequences of the actions of superiors. The actions of superiors were seen as affecting the subordinates' perceptions of reaching their own personal goals. Testing occurred in a public utility and in a hospital. In the public utility, the superior's behavior affected

subordinates' perceptions of the instrumentality of such behavior for reaching personal goals on the part of subordinates involved. The superior's behavior was positively related to job performance and job satisfaction of the employees. No such relationship occurred in the hospital.

Nealey and Blood (1968) investigated the relationship between leadership style and behavior and both work group performance and job satisfaction of subordinates at different organizational levels. Twenty-two top level and eight lower level nursing supervisors comprised the sample. They found that Task oriented, top level and Relationship oriented, lower level supervisors received higher performance ratings. Job satisfaction was positively related to the leader's Consideration at both levels. Also, at the top level, Initiating Structure had a positive relationship to subordinates' job satisfaction, but in the case of the lower level leaders, Initiating Structure was inversely related to subordinates' job satisfaction.

Reilly (cited in Georgopoulos, 1975) tested a contingency model of leadership effectiveness with 86 nursing students. Relationship oriented leadership was positively related to group effectiveness, whether group tasks were structured or unstructured. He found that Task oriented leaders interacted more with group members and were more supportive. Relationship oriented leaders were more directive. This finding is opposite of the typical pattern obtained in many industrial studies.

Anderson (1964), in a two part study, examined the role of Head Nurse as leader of other nurses, by looking at the relationship of the Head Nurses' leadership and activity preferences. A questionnaire was given to 25 Head Nurses and 79 staff nurses to check effective leadership from the point of view of subordinates. Most Head Nurses indicated a preference for personnel activities, but those Head Nurses who indicated a preference for nursing care activities were rated higher in leadership effectiveness by their subordinates than were the Head Nurses who preferred personnel or coordinative activities. Leaders rated higher by subordinates were better in the area of consideration for others. The second part of the study rated the Head Nurses by their superiors. The ratings were then compared to the first part of the study. It was found that Head Nurses who preferred coordinative activities were rated higher and were seen as better leaders by the superiors. This study demonstrated that nursing staff and nursing supervisor's differed in their view of Head Nurse activities considered to be effective and examples of "good" leadership.

Whitner (cited in Georgopoulos, 1975) utilizing a critical incident technique, studied Head Nurse leadership behaviors. An analysis of 900 questionnaires from supervisory and non-supervisory nurses in five general and six psychiatric hospitals showed that leadership was related to consistency

of supervisory behaviors manifested over a variety of situations, rather than to behaviors evidence in any specific situation. The Head Nurse in general was seen as most effective in supervising patient care and least effective in communicating with co-workers. Behaviors linked to Head Nurse leadership showed a high agreement among subordinates, peers and superiors.

Nursing literature has increased its emphasis on the importance of leadership in nursing (Krohn, 1961; Beyers & Phillips, 1971; Douglass & Bevis, 1974). There have been few studies of leadership reported on nursing populations. What is most evident in the review of the literature is the apparent contradictions in what is reported. For example, McBride (McBride, et al, 1972) stresses the nurturing nature of nurses, while Corrigan and Julian (1966) identify the nurses' MMPI profiles do not contain characteristics that could be labeled as nurturing.

According to the characteristics of self-actualized persons described by Rogers (1951, 1961), Maslow (1954), Jourard (1974), and Combs and Snygg (1959), it is possible to develop more positive self concepts. The study by Coleman and Glofka, on one hand, demonstrated that it is possible to change the self concept scores of senior nursing students. Diers (McBride, et al, 1972) and Corrigan and Julian (1966), on the other hand, characterize nurses in a way which could only be described as indicative of a "poor"

self concept. In addition, Eiseman (1970) has found that students in nursing programs become less creative during their educational experience which is not consistent with the characteristics of self-actualized persons.

Whereas nursing leadership literature identifies leadership as a function of all nurses, Leininger (1974), stresses that leadership style and leadership effectiveness has not been given adequate study in nursing. This is a most contradictory statement.

The above demonstrates just a few of the inconsistencies and confusion, for the investigator, around the areas of self concept, and self- and other-perception of leadership style and effectiveness. Because nursing is considered a helping profession that involves relating to a variety of others, and because nurses are often designated or viewed as leaders, it becomes apparent that nurses in leadership positions must be studied for leadership styles and effectiveness.

Statement of Hypotheses

Based on the review of the literature related to the theories of self concept and self and other perceived leadership style and effectiveness, the following hypotheses were identified for this study.

I. The greater the extent of positive self concept, the greater the congruence between one's own self perception of leadership style and effectiveness

and the perception by others of the leader's leadership style and effectiveness.

II. The greater the congruence between the leader's self perception and the perception of the leader by others, the greater the effectiveness of the leader.

III. The greater the extent of positive self concept, the greater the perceived effectiveness of the leader.

The general hypotheses were further specified (Figure 1) as follows:

1. The self concept will be positively related to the congruence between the leadership style on the LOQ and the leadership style described by subordinates on the LBDQ.

2. The self concept will be positively related to the congruence between the leadership style scores on the LEAD-Self and the leadership style scores by subordinates on the LEAD-Other.

3A. The congruence between scores on the LOQ and LBDQ will be positively related to the Leadership Effectiveness Rating Form scores of the superiors.

3B. The congruency between scores of the LOQ and LBDQ will be positively related to the Leadership Effectiveness Rating Form scores of the subordinates.

4A. The congruency between scores on the LEAD-Self and the LEAD-Other will be positively related to the Leadership Effectiveness Rating Form scores of the superiors.

4B. The congruency between scores on the LEAD-Self and the LEAD-Other will be positively related to the Leadership Effectiveness Rating Form scores of the subordinates.

5. The Initiating Structure and Consideration scores on the LOQ will be positively related to the Initiating Structure and Consideration scores described by the LBDQ.

6. The leadership style scores and effectiveness scores on the LEAD-Self will be positively related to the leadership style scores and effectiveness scores on the LEAD-Other.

7. The Initiating Structure and Consideration scores on the LOQ will be positively related to the dominant leadership style scores of Task Behavior and Relationship Behavior on the LEAD-Self.

8. The Initiating Structure and Consideration scores described by the LBDQ will be positively related to the dominant leadership style scores of Task Behavior and Relationship Behavior on the LEAD-Other.

9. The Leadership Effectiveness Rating Form scores

of the subordinates will be positively related to the Leadership Effectiveness Rating Form scores of the superiors.

A significance level of .05 was selected as necessary for support of the hypotheses. The predicted relationships of the hypotheses of the study may be found in Figure 2.

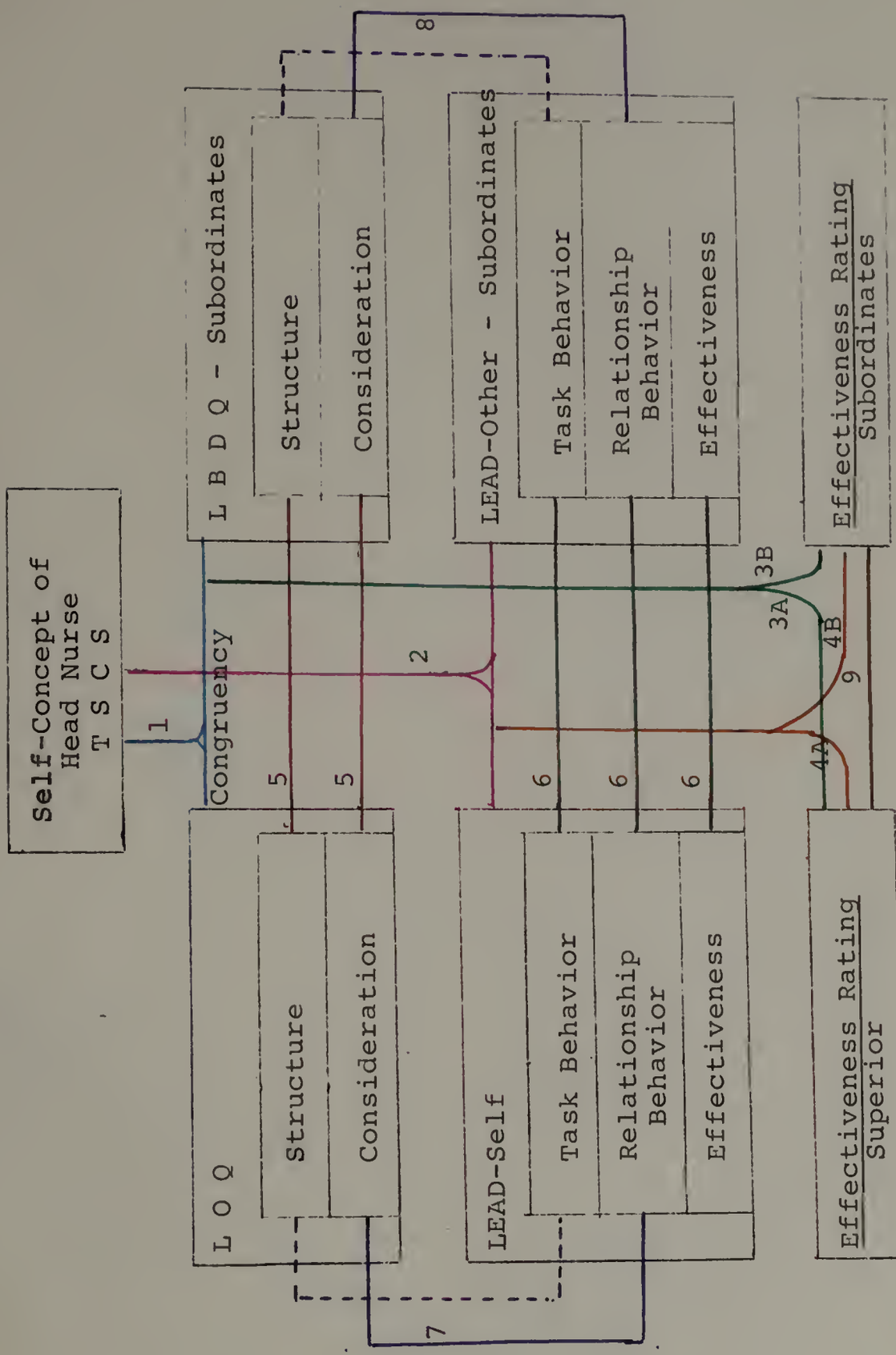

Figure 1. Graphic Representation of Hypotheses Being Tested in Study.

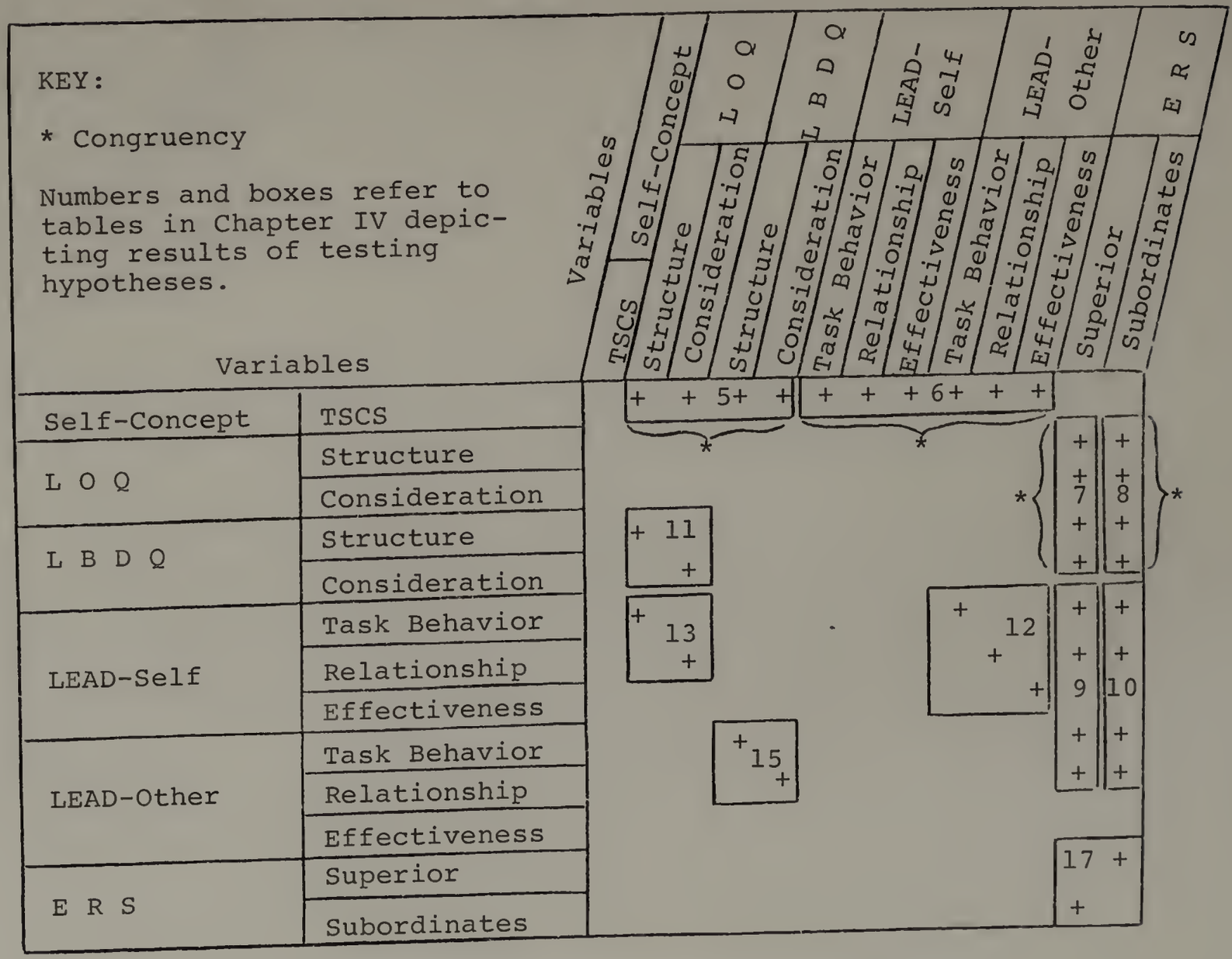

Figure 2. Predicted Relationships of Hypotheses of Study.

C H A P T E R I I I

RESEARCH DESIGN AND METHODOLOGY

Introduction

This chapter presents a detailed description of the research design, methodology and procedures used in the study. Separate sections detail the description of the study, the research facilities and the description of the sample. These sections are followed by a restatement of the general hypotheses, the instrumentation used in the study and the process of data collection. The final section describes the procedures used to analyze the data.

Description of the Study

The study was designed to be exploratory in nature and to test certain assumptions related to self concept and leadership style and effectiveness as perceived by self and others. These assumptions have already been discussed in Chapter I. The specific hypotheses may be found in Chapter II.

The design of the study involved first, the obtaining of data from Head Nurses concerning self report of self concept, self-perceptions of leadership style for Consideration and Initiating Structure and self-perceptions of leadership style for Task and Relationship Behaviors. Data were next obtained from the members of the nursing staff

for each Head Nurse. These data provided scores for leadership styles of Consideration and Initiating Structure and scores for leadership styles of Task Behavior and Relationship Behavior, a leadership effectiveness score and a Leadership Effectiveness Rating Form score for each Head Nurse as perceived by the staff member. A final source of data included a rating of the effectiveness of the Head Nurse as perceived by Nursing Supervisors. Each Nursing Supervisor completed a Leadership Effectiveness Rating Form for all of the Head Nurses for whom the supervisor assumed primary or secondary responsibility. Figure 3 shows the various instruments that were completed by the participants in the study.

Sub-Populations	Instruments of Measurement					
	TSCS	LOQ	LBDQ	LEAD-SELF	LEAD-OTHER	ERS
Head Nurses	X	X		X		
Nursing Staff			X		X	X
Nursing Supervisor						X

Figure 3. Instruments Completed by Study Subpopulations.

Research Facilities

Cooley Dickinson Hospital in Northampton, Massachusetts, and Wesson Memorial Hospital in Springfield, Massachusetts, were selected, for several reasons, as the facilities for implementation of the study.

First, both health care systems are general, acute care community hospitals of comparable, medium size. Similar services are provided in both settings, including nursing care of adult patients with medical or surgical conditions, intensive care units, and small pediatric units.

Secondly, the Director of Nursing Service in each agency was interested in and supportive of the purposes of the study. Each Director indicated the value of the information obtained concerning self-perceptions of leadership of their Head Nurses and perceptions of Nursing Staff which could reflect, favorably or unfavorably, on their administrative, promotional, decision-making processes. The Directors believed that the data obtained would confirm or negate their own assessments of the Head Nurse's degree of effectiveness.

The final reason for selecting the two agencies was that neither agency, alone, contained a sufficient number of Head Nurses from which to obtain data. The use of the two agencies allowed for replication of the study since all data were obtained from the sample at Cooley-Dickinson Hospital (Agency A) before they were obtained from the

Wesson Memorial Hospital sample (Agency B).

Description of the Sample

The sample employed in the study consisted of a total of 22 Head Nurses, 7 Nursing Supervisors and 157 members of the Nursing Staff. Two Head Nurses at Agency A were deleted from the study because there were fewer than four staff members available from whom data could be obtained for the perception of leadership style and effectiveness. A summary of the description of the sample by position, mean age and mean length of time in the position may be found in Table A, Appendix J.

The Agency A sample component was comprised of 10 Head Nurses, 3 Nursing Supervisors and 62 members of the Nursing Staff. The sample component for Agency B contained 12 Head Nurses, 4 Nursing Supervisors and 95 Nursing Staff members. Figure 4 diagrams the hierarchical structure of the various participants in the study.

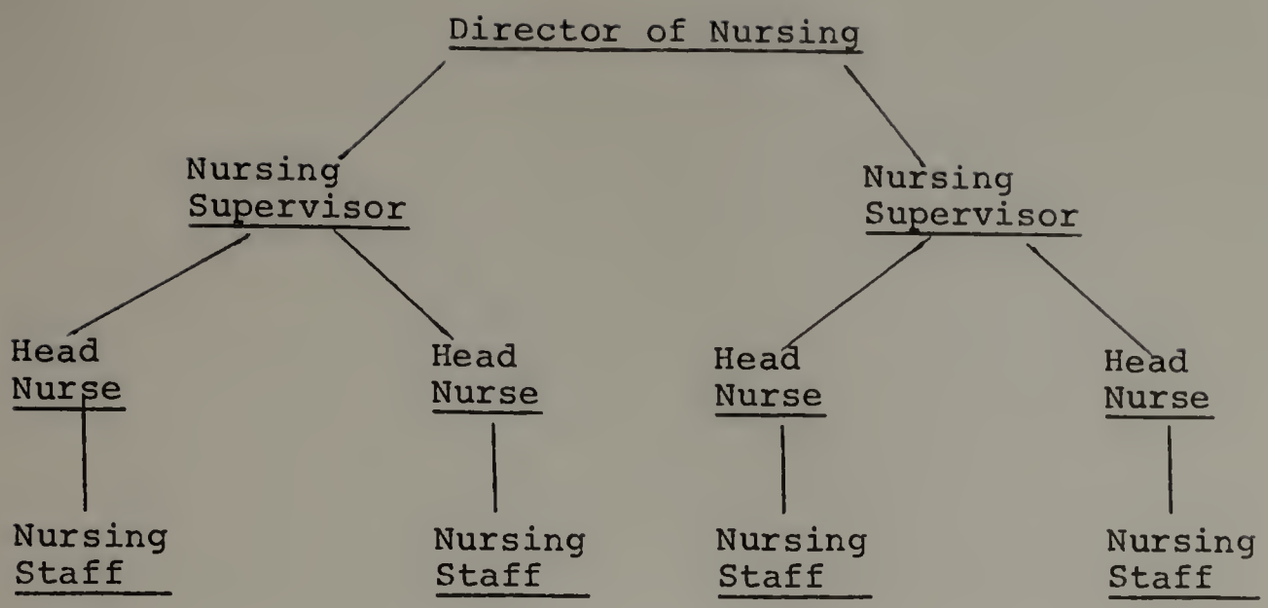

Figure 4. Reporting Lines for Study Subpopulations

The ages of the Head Nurses in Agency A ranged from 28 to 60, with the mean age of 45 years. The average length of time in the position of Head Nurse was 8.4 years.

In Agency B, the ages of the Head Nurses ranged from 27 to 63, with the mean age being 42. The average length of time in the Head Nurse position was 4.2 years.

For the Nursing Supervisors in both agencies, the range of ages was 48 to 60. The average age was 51 and 52 respectively, with the mean length of time in the position of 14.3 years and 9.25 years.

The Nursing Staff component of the sample in Agency A included 37 Registered Nurses whose mean age was 33 years and whose length of time in the position was 4.1 years. There were 14 Licensed Practical Nurses, mean age 35.4 and mean length of service 4.7 years and 11 Aides whose mean age

was 45 years and whose mean length of employment in the position was 8.8 years.

The Nursing Staff component of the sample in Agency B contained 37 Registered Nurses, 33 Licensed Practical Nurses and 25 Aides/Orderlies. The mean age and years of employment in the position for each of the subgroups was 32 years of age and 4.3 years of service, 36 years of age and 6 years of service and 32 years of age and 3.4 years of service, respectively.

The population in Agency A was 100% (N = 75) female, while Agency B was comprised of a 97% (N = 108) female population and a 3% (N = 3) male population. The total composition of the sample was 98% female and 2% male.

The basic nursing education program for the Head Nurses and Nursing Supervisors in both groups was a diploma program. The vast majority of the Registered Nurses in the Nursing Staff for both groups also obtained their basic nursing education in diploma programs. This was true for 91% of the Registered Nurses at Agency A and for 76% of the Registered Nurses at Agency B. Three (8%) of the Registered Nurses at Agency A obtained their nursing education in an associate degree program in a community college, while five (14%) of the Registered Nurses at Agency B obtained an associate degree. There were no baccalaureate graduates represented in the sample from Agency A, while three (8%)

of the Registered Nurses at Agency B were graduates of a basic baccalaureate nursing education program.

A total of 77 nursing service personnel were contacted in Agency A, with two staff members electing not to participate in the study. This brought the size of the Agency A sample to 75. There were also two members of the Nursing Staff in Agency B who elected not to participate in the study, brining the Agency B sample total to 111. There were no refusals to participate from Nursing Supervisors nor from Head Nurses in either group.

Instrumentation

Data were obtained from the two agency groups by having the Head Nurses, Nursing Staff and Nursing Supervisors complete specified instruments. The instruments will be more full described at this point.

The Tennessee Self Concept Scale - The TSCS is a self report scale of self concept developed by William H. Fitts (1965). It is available in both a Counseling Form and a Clinical and Research Form, the former being selected for use in this study, since only the Total Positive Score and Self-Criticism Scores were to be used in the data analysis. A copy of the instrument may be found in Appendix A.

The TSCS contains 100 self-description items of which 90 items assess the self concept and 10 items assess self criticism. Subjects respond on a five point scale ranging

from "completely true" to "completely false".

The TSCS provides 15 profile scores including:

> Self criticism, 9 self esteem scores (identity, self satisfaction, behavior, physical self, moral-ethical self, personal self, family self, social self, total), 3 variability of response scores (variation across first 3 of the self esteem scores, variation across the last 5 self esteem scores, total), distribution score, time score (Buros, 1972, p. 364).

According to Fitts (1971), the construction and development of the TSCS is based on the theoretical frameworks of Snygg and Combs (1949), Rogers (1951) and Maslow (1954). The scale was constructed in 1965 for the "purpose of obtaining measures of many facets of the individual's self concept, such as self-esteem, defensiveness, conflict, confusion, and variability in self-perception" (Fitts, 1971, p. 71).

Fitts (1971) defines the categories for the profile scores as:

a. Identity- items pertaining to what the individual is, his Identity Self.
b. Self Satisfaction- items describing how a person feels about himself, the Judging Self.
c. Behavior- items describing what an individual does or how he acts, the Behavioral Self.

These three categories constitute an internal frame of reference, while the following five categories constitute an external frame of reference.

a. Physical Self- items pertaining to physical attributes or functioning, sexuality, state of health, and appearance.
b. Moral-Ethical Self- items dealing with moral, ethical and religious aspects of self.
c. Personal Self- items describing personal worth or adequacy, self respect, and self-confidence.

d. Family Self- items describing the nature of an individual's relationship with his primary group and his sense of adequacy as a family member.
e. Social Self- items dealing with one's sense of adequacy or worth in relationships with people in general (pp. 42-43).

Validity and reliability data for the TSCS, as reported in the Manual (Fitts, 1965) indicates that normative data were obtained from a sample of 626 persons of varying age, sex, race and socioeconomic status. The norms for the instrument were based on a heterogeneous population. Test-retest reliability for that sample ranges from .92 for the Total Positive Self Esteem Score to the high .80's for the different profile scores. The Cornell Medical Index correlates from .50 to .70 and various MMPI scale correlations are in the .50's or .60's to indicate Convergent Validity. According to Bentler (1972) the Taylor Anxiety Scale correlation is -.70 with the Total Positive Self Esteem Score.

For Discriminant Validity, Crandall (1973) indicates that the Total Positive Self Esteem Score on the TSCS did not correlate strongly with the F Scale on the Minnesota Multiphasic Personality Inventory. There has been no correlation with social desirability reported.

Fitts (1972a) reports on a few studies that bear on the Predictive Validity of the TSCS in relation to school dropouts, rehabilitation success of juvenile delinquents and vocational choice. He believes that the TSCS is a partial predictor of the caliber of an individual's job performance, just as one's self concept can be affected by the nature

and quality of one's work.

Wylie (1974) criticizes the TSCS because of the non-independence of the subscores which she believes may lead to over interpretations of the profiles. Fitts (1971) indicates that the interpretation of the TSCS has always been intended to be a subject's reported self concept. The individual's report can be accepted as that self concept which he is willing to make public (p. 54).

The Total P-Score, or Total Positive Self Esteem Score and the S-C, or Self Criticism Score were the two scores used in the analysis of data and hypotheses testing in this study. The Total Positive Score was selected because it reflects the overall level of self esteem. Individuals with high scores tend to view themselves as having value and worth. They like themselves, have confidence in their own abilities and act accordingly (Fitts, 1965, p. 2). The Total Positive Score is comprised of items 1 through 90 on the instrument found in Appendix A. The Self Criticism Score consists of items 91 through 100 on the instrument in Appendix A.

The Self Criticism Score was also selected for analysis, since this score, if high, indicates an openness and capacity for self criticism. Individuals with low scores are most often identified as being defensive and of making a deliberate attempt to present themselves in a favorable light. Individuals who score above the 99th percentile may be without

defenses while those with low scores may be defensive. If the Self Criticism Score is low, then one would suspect that the Total Positive Score is artifically elevated (Fitts, 1965, p. 2).

Leader Behavior Description Questionnaire- The LBDQ (Appendix D) was developed by personnel at Ohio State University as a result of work initiated by Hemphill and the Ohio State Leadership Studies. It provides for the description of leader behavior of designated leaders in formal organizations as perceived by group members. The form produces independent scores for two fundamental dimensions of leader behavior entitled Initiating Structure and Consideration. The respondent indicates the frequency (always, often, occasionally, seldom, never) with which he or she perceives the leader to engage in specific examples of leader behaviors. The range of scores for each of the two dimensions is 0 to 60.

According to the Manual (Halpin, 1957), the estimated reliability, using the split-half method, has been found to be .83 for Structure and .92 for Consideration scores. In several studies, analysis of variance has demonstrated F ratios that have been significant at the .01 level, indicating that followers tend to agree in their description of the leader's behavior and that the difference in the descriptions of different leaders are statistically significant (p. 1).

Halpin (1957) indicates that a minimum of four respondents for each leader is necessary to provide a satisfactory index score for Initiating Structure and Consideration. Any increase of respondents beyond ten does not increase the stability of the score. The leader's Structure and Consideration scores are computed by averaging the scores obtained from the respondents for the two leadership dimensions.

Because the leader sample in the study was comprised of a total female sample, the LBDQ, with permission, was adapted to reflect the leader's title of Head Nurse and to describe each behavior as "She" rather than "He" as in the original LBDQ.

The LBDQ has been widely researched and widely used in studies of leadership (Halpin & Winer, 1957; Stogdill & Coons, 1957; Stogdill & Shartle, 1955). Gibb (cited in Buros, 1972) describes the Ohio State Leadership Studies as "the most notable, and the most complete research directed toward the determination of dimensions of leader behavior" (p. 1529).

Leader Opinion Questionnaire- Ohio State Model- The LOQ (Appendix B) used in this study was adapted from the LBDQ by making proper changes in the directions and by changing the leader behaviors in the questionnaire from "She" to "I". The scoring range for the two dimensions of Initiating Structure and Consideration were from 0 to 60,

as in the LBDQ. Strictly speaking, the same comments pertaining to reliability and use in studies cannot be made for the LOQ used in this study since it was an adaptation of the LBDQ and not the same instrument as the Leadership Opinion Questionnaire copyrighted by Edwin A. Fleishman (1960). However, the modifications made are minor modifications of an instrument with known reliability.

Leader Effectiveness and Adaptability Description- Self and Leader Effectiveness and Adaptability Description- Other- The LEAD-Self (Appendix C) and LEAD-Other (Appendix E) are instruments developed by Paul Hersey and Kenneth H. Blanchard to measure Task and Relationship Behaviors of leaders as perceived by self and others, respectively. Scores obtained provide information on the dominant leadership style, the range of leadership styles available to the leader, and a measure of leadership effectiveness. The respondents select one of four possible actions for each of the twelve situations that they believe most closely matches the behavior of the leader described. Each of the four alternative actions are consistent with one of the four possible leadership styles of the Life Cycle Theory of Leadership--High Task/Low Relationship (HT,LR), High Task/High Relationship (HT, HR), High Relationship/Low Task (HR, LT), or Low Task/Low Relationship (LT, LR). The range of possible scores is 0 to 12 for any

one quadrant of leadership style, with a total of 12 being distributed among the four quadrants. The leadership style scores in the four quadrants are not independent of each other, so if a respondent has scores of 3,3 and 4 for the first three quadrants, one knows automatically that the fourth quadrant will have a score of 2.

Hersey and Blanchard (1972) define leadership effectiveness as the appropriateness of the style of the leader to a given situation. When the leader's style is inappropriate to a given situation, it is termed ineffective (p. 83). A scoring form (Appendix H) provides both the scores for the leadership style quadrants and for leadership effectiveness. The leadership effectiveness score, ranging from -24 to +24, indicates the ability of the leader to adapt his or her leadership style to meet the needs of the followers and the needs of the situations as described by the instrument.

The LEAD-Self and LEAD-Other instruments have been administered to over 10,000 people, and the instruments seem to have Face Validity. However, there has been no work done on reliability, nor has there been work done on content validity. Since the instruments have been used mainly as training instruments, it is hoped and expected that the scores will change when administered to the same group at two different times, i.e., pre- and post-training sessions (Blanchard, 1975).

Both of the LEAD instruments are based on the Life Cycle Theory of Leadership advanced by Hersey and Blanchard (1972) which stresses the curvilinear relationship between Task Behavior, Relationship Behavior and the maturity level of the followers. Task Behavior and Relationship Behavior are defined in the same manner as Initiating Structure and Consideration, respectively. The latter terms are found in the Ohio State University Studies in Leadership, LBDQ and LOQ forms from which the Life Cycle Theory of Leadership was derived in part.

Leadership Effectiveness Rating Form- The ERS (Appendix F) was developed by the investigator as a Likert-type scale to measure leadership effectiveness of the Head Nurse as perceived by subordinates and superiors. It is a six item scale with a range for each item of from 1 to 7, with 7 being the highest score. The form contained one item that measured overall effectiveness of the Head Nurse. Another item measured overall job satisfaction. Four additional items, identified as dimensions of effectiveness, related to assistance in Planning Nursing Care, Supervision, Communication and Delegation. The dimensions were selected because they reflect the major areas of Head Nurse responsibility that appear to be dominant in nursing literature (Alexander, 1972; Arndt & Huckabay, 1975; Barrett, 1968; Shanks & Kennedy, 1970).

The Leadership Effectiveness Rating Form was pre-tested with three colleagues of the investigator. It was evaluated in terms of clarity of directions, clarity of scale, and applicability to nursing leader effectiveness measures. There were no changes seen as necessary prior to administration of the tool with the sample in the study.

Personal Data and Permission Form- This form was completed by all individuals who voluntarily participated in the study. It provided the investigator with personal data related to sex, age, job responsibilities, educational preparation and length of time in their current position. The form also indicated the individual's consent to participate in the study and the release, for publication, of the results while guaranteeing anonymity of individual and agency data. A copy of the form may be found in Appendix G.

Data Collection

The data were collected in the summer of 1975. The investigator met individually with the Directors of Nursing Service at both Cooley-Dickinson Hospital and Wesson Memorial Hospital in May, 1975. The purpose of the study was discussed with each and all materials to be used in the study were shared with the Directors. Both Directors agreed to participate in the study, understanding that participation by Head Nurses, Nursing Staff and Nursing Supervisors would be voluntary.

The Directors then arranged a Head Nurse/Nursing Supervisor meeting in their respective agencies, in order for the investigator to explain the study to the Head Nurses and ask for their participation. All of the Head Nurses, twelve at each agency, agreed to participate in the study. The data were collected at the initial meeting with the Head Nurses in Agency A. Another meeting was arranged in order to collect the data from the Head Nurses in Agency B.

Each Director then arranged for a series of meetings at which time members of the Nursing Staff were freed from their nursing units to attend a meeting for explanation of the study and request for their participation by the investigator. A total of four staff members elected not to participate in the study, two from each agency. One staff member declined to participate because of a language barrier that interferred with her understanding the printed material on the forms. A second staff member declined because of the Assistant Head Nurse position she held in the agency, although the investigator assured her that data had been collected from other staff members in that same position. A third staff member refused to participate because she believed she could not fairly answer the questionnaires due to "difficulties in relationships with the Head Nurse that were just being resolved". The final staff members who declined to participate did so on the basis of "not wanting to commit myself. Everyone is hired to do a job and we all

have our good and our bad days." Each of the four non-participants worked with a different Head Nurse.

The data from the supervisors were obtained by meeting with the three supervisors in Agency A and collecting Leadership Effectiveness Rating Forms for each of the 10 Head Nurses in the Group. The study was explained to the supervisors in Agency B during the meeting with the Head Nurses. The necessary number of Leadership Effectiveness Rating Forms were left with the supervisors and were later obtained by the investigator.

Data collection continued for both agencies from the first of June, 1975 through the end of July, 1975. There was a need to make several additional trips to both agencies in order to obtain data from Nursing Staff who were unable to attend the group meetings organized. This was especially true for the specialty nursing units, such as Operating Room, Recovery Room, Intensive and Coronary Care Units, etc., where Nursing Staff could not be away from the patient care setting, but could be relieved for a period of time in order to complete the forms.

In each instance, the investigator was as consistent as possible in explaining the purposes of the study, in requesting voluntary participation in the study, and in giving directions for obtaining the data. The outline of instructions given to participants may be found in Appendix I.

The time involved for completion of the forms averaged 35 minutes for the Head Nurses. The Nursing Staff's average time to complete the forms was 25 minutes, and the Nursing Supervisors' average time for form completion was 15 minutes.

Except for the Personal Data and Permission Form, which contained the individual names of each member of the sample, all other forms were coded so that anonymity was assured to the participants. The code numbers were known only to the investigator.

The data were obtained separately for Head Nurses, Nursing Staff and Nursing Supervisors in both groups. Both the anonymity and separate collection of data measures taken were consistent with the administration recommendations of Halpin (1957) and Stogdill (1963) who indicate that it is best to guarantee anonymity of the respondents, and preferable not to have the leader being described present when subordinates are completing the form.

Data Analysis

The data collected from each Head Nurse in both groups included the Total Positive Self Esteem Score and the Self Criticism Score on the Tennessee Self Concept Scale (Appendix A); Initiating Structure and Consideration scores from the Leader Opinion Questionnaire-Ohio State Model (Appendix B);

Leader Effectiveness and Adaptability Description-Self scores (Appendix C, Appendix H) for each of the four leadership style quadrants and an effectiveness score. In addition, personal data concerning age, sex, nursing education background and length of time in position were collected.

The Nursing Staff members in the sample provided the following scores related to their perceptions of their Head Nurse's leadership style and effectiveness which were used to compute means for:

1. Initiating Structure and Consideration scores based on the Leader Behavior Description Questionnaire (Appendix D).
2. Range of leadership styles in the four quadrants of the Leader Effectiveness and Adaptability Description-Other, the dominant other-perceived leadership style and the leader effectiveness score (Appendix C, Appendix H).
3. Leadership Effectiveness Rating Form score for Overall Effectiveness, Overall Job Satisfaction, Planning Nursing Care, Supervision, Communication Channels and Delegation of Responsibility (Appendix F).

In order to test the hypotheses of the study, Pearson product moment correlations were computed on the pairs of variables already identified in Figures 1 and 2 found in Chapter II. A .05 level of significance was selected as

appropriate for rejection of the specific hypotheses.

This chapter has presented a detailed description of the research design, methodology and procedures used in the study. A description of the study, research facilities, sample description, hypotheses, instrumentation, data collection methods and data analysis procedures has been described in detail. The results and analysis of the investigation will be presented in the following chapter.

C H A P T E R I V

RESULTS

Introduction

This chapter presents the results of the study. The data are presented in statistical format with discussion following. Implications of the study are discussed in detail in Chapter V.

The remainder of this chapter is divided into fifteen sections. The first two sections give the scores on the various instruments and the analysis of variance results. Sections three through thirteen give data for each of the hypotheses tested in the study. The final two sections give additional correlations and a summary of the results of the data analyses, respectively.

Description of Scores

Table 1 gives the self concept scores for the Head Nurses, along with comparable normative data. The standardized group from which the norms were developed was a sample of 626 people, representing various ages, social, economic, intellectual and educational levels (Fitts, 1965).

As can be seen in Table 1, the mean Total Positive Score for the Head Nurses is well above the mean reported for the norm group, suggesting that the nurses have more positive self concept scores than the more diverse group on which the instrument was standardized. The smaller size

TABLE 1

MEANS AND STANDARD DEVIATIONS FOR TOTAL POSITIVE AND SELF CRITICISM SCORES ON TENNESSEE SELF CONCEPT SCALE

Sample Groups	TSCS			
	Total Positive Score		Self Criticism Score	
	Mean	Standard Deviation S.D.	Mean	Standard Deviation S.D.
Head Nurses Agency A (N = 10)	388.50	18.64	35.10	5.30
Head Nurses Agency B (N = 12)	390.92	21.57	34.67	4.92
Head Nurses Combined Agency Group (N = 22)	389.82	19.85	34.86	4.98
Norm Group (N = 626)	345.57	30.70	35.54	6.70

of the standard deviation for the Head Nurses indicates that they are a more homogeneous group than the norm group. The Head Nurses in each agency are almost identical in their scores. Since the Self Criticism scores for the Head Nurses are consistent with the reported norm scores, one may conclude that the Total Positive scores for the nurses are not artificially elevated (Fitts, 1965). The Total Positive scores for the Head Nurses can be accepted as accurate scores of self report of self concept.

Table 2 gives the mean scores for both Head Nurses and Nursing Staff on the two instruments used to measure leadership style.

The range of possible scores on the LOQ and LBDQ is from 0 to 60. Inspection of the table indicates that the Head Nurses tended to view themselves higher, and with less deviation, on the Structure and Consideration dimensions than did their Nursing Staff. This is evident in the positive direction of the discrepancy scores found in the D-Score column. Figure 5 depicts the LOQ and LBDQ scores in both agencies using a four quadrant grid. Although all four sets of scores indicate self and other perceived leadership style as high in Structure and Consideration, it is less so for the Nursing Staffs' scores. In each agency, the Head Nurses are more consistent with each other in their LOQ scores, then they are with the views of their respective

Table 2

Means, Standard Deviations and Discrepancy Scores
on Leadership Instruments for Head Nurses

Variables	Agency A			Agency B			Combined Group		
	Mean	S.D.	D-Score	Mean	S.D.	D-Score	Mean	S.D.	D-Score
Leader Opinion Questionnaire Structure	50.40	5.87	9.05	50.33	3.52	7.88	50.36	4.61	8.41
Leader Behavior Description Q. Structure	41.35	5.99		42.45	6.80		41.95	6.32	
Leader Opinion Questionnaire Consideration	49.40	4.88	7.06	48.00	5.08	7.19	48.64	4.92	7.14
Leader Behavior Description Q. Consideration	42.34	8.31		40.80	5.46		41.50	6.77	
LEAD-Self: HT, LR	3.10	1.29	1.27	1.67	1.37	-.73	2.32	1.49	.18
LEAD-Other: HT, LR	1.82	.59		2.40	1.41		2.14	1.13	
LEAD-Self: HT, HR	6.40	1.50	1.64	7.16	1.80	2.16	6.82	1.68	1.93
LEAD-Other: HT, HR	4.76	2.38		5.00	1.18		4.89	1.78	
LEAD-Self: HR, LT	2.30	1.16	-.62	2.83	1.19	.12	2.59	1.18	-.22
LEAD-Other: HR, LT	2.92	1.07		2.71	1.15		2.81	1.09	
LEAD-Self: LT, LR	.20	.42	-2.23	.33	.65	-1.54	.27	.55	-1.85
LEAD-Other: LT, LR	2.43	2.50		1.87	1.02		2.12	1.82	
LEAD-Self: Effectiveness	5.10	3.51	2.39	6.92	4.23	3.54	6.09	3.93	3.01
LEAD-Other: Effectiveness	2.71	2.55		3.38	3.06		3.08	2.80	

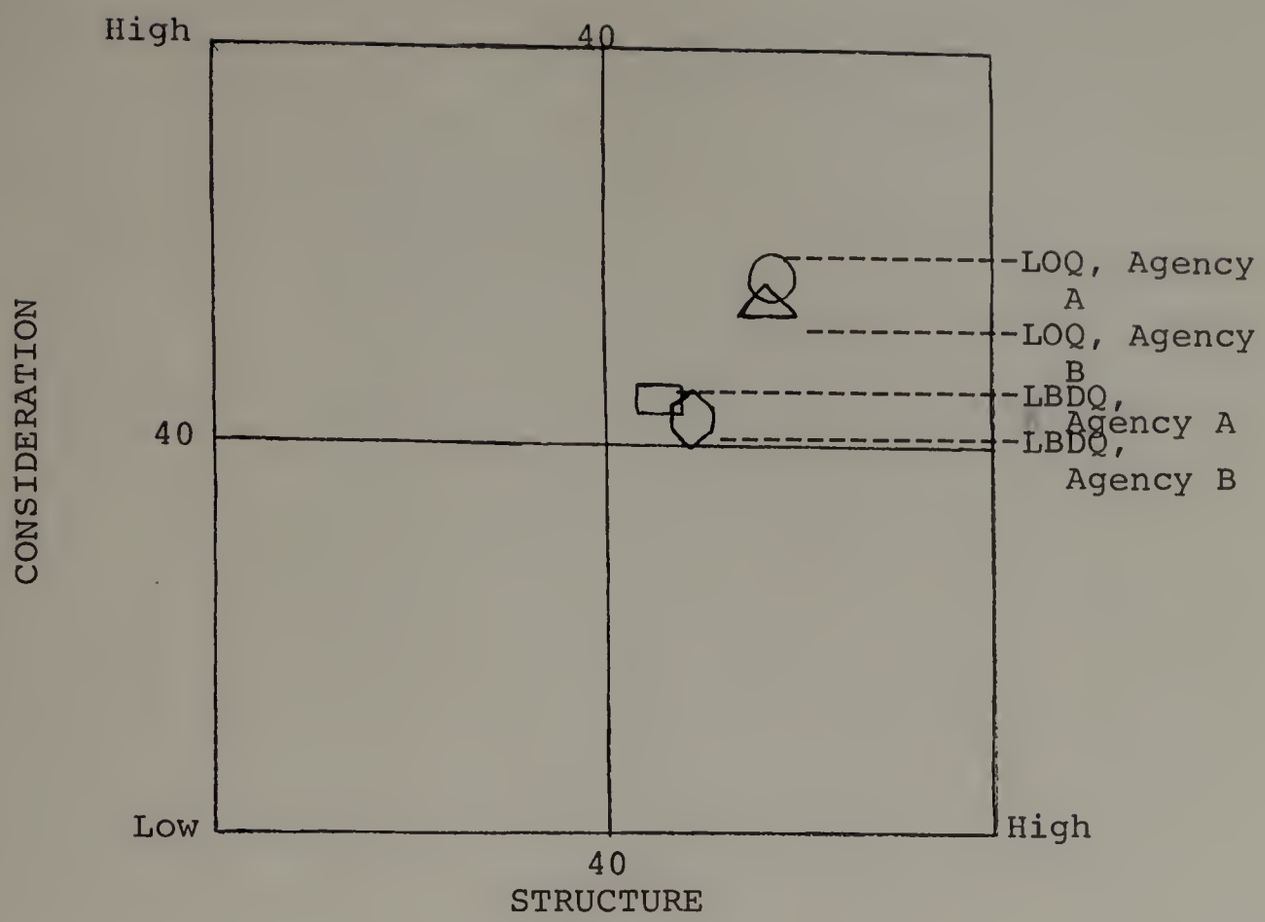

Figure 5. LOQ and LBDQ Scores for Head Nurses in Both Agencies

Nursing Staff. The same may be said for the Nursing Staffs' scores on the LBDQ in each agency. The scores were dissimilar between the Head Nurses and their Nursing Staff.

Inspection of the LEAD instrument scores given in Table 2 indicate that the Head Nurses view themselves as having a dominant leadership style of High Task/High Relationship as do the Nursing Staff. Again, the D-Scores show that the Head Nurses' scores were higher for this dimension than the staffs' scores.

With the range of scores on the LEAD instruments being 0 to 12 for any one quadrant, the table shows that the Head Nurses' scores for the High Task/High Relationship quadrant account for over half of the possible total score of 12. Although the actual sequence differs in each agency, the Head Nurses' range of leadership styles includes the High Task/High Relationship, High Relationship/Low Task and High Task/Low Relationship quadrants. They tend to see themselves rarely using a Low Task/Low Relationship leadership style.

For the Nursing Staff, inspection of Table 2 indicates a more even distribution of scores for all four leadership styles. As indicated previously, the Nursing Staff also viewed the Head Nurses as having a High Task/High Relationship leadership style. This was followed in frequency by a High Relationship/Low Task style. The Nursing Staff tend to

view the Head Nurses as using a Low Task/Low Relationship leadership style more frequently than the Head Nurses do themselves.

By combining the dominant and supportive leadership style scores for the Head Nurses and for the Nursing Staff, it is possible to depict the scores on a four quadrant grid for each agency (Figures 6 and 7). The grid represents the Life-Cycle Theory of Leadership described by Hersey and Blanchard (1972). The figures show the discrepancy between the views of the Head Nurses and their Nursing Staff on the LEAD instruments.

The final scores given in Table 2 are for the effectiveness dimension on the LEAD instruments. The possible scores range from +24 to -24 for this dimension. The score reflects the ability to diagnose the maturity level of followers in each of 12 situations given in the instrument and select the most appropriate leadership style for the situation. If done correctly, there would be a perfect effectiveness score of +24 with a score of 3 in each of the four leadership style quadrants. As can be seen in Table 2, the effectiveness scores for the Head Nurses are higher than are those from their Nursing Staff. Although the range of leadership styles available to the Head Nurses is more limited than the range as viewed by the Nursing Staff,

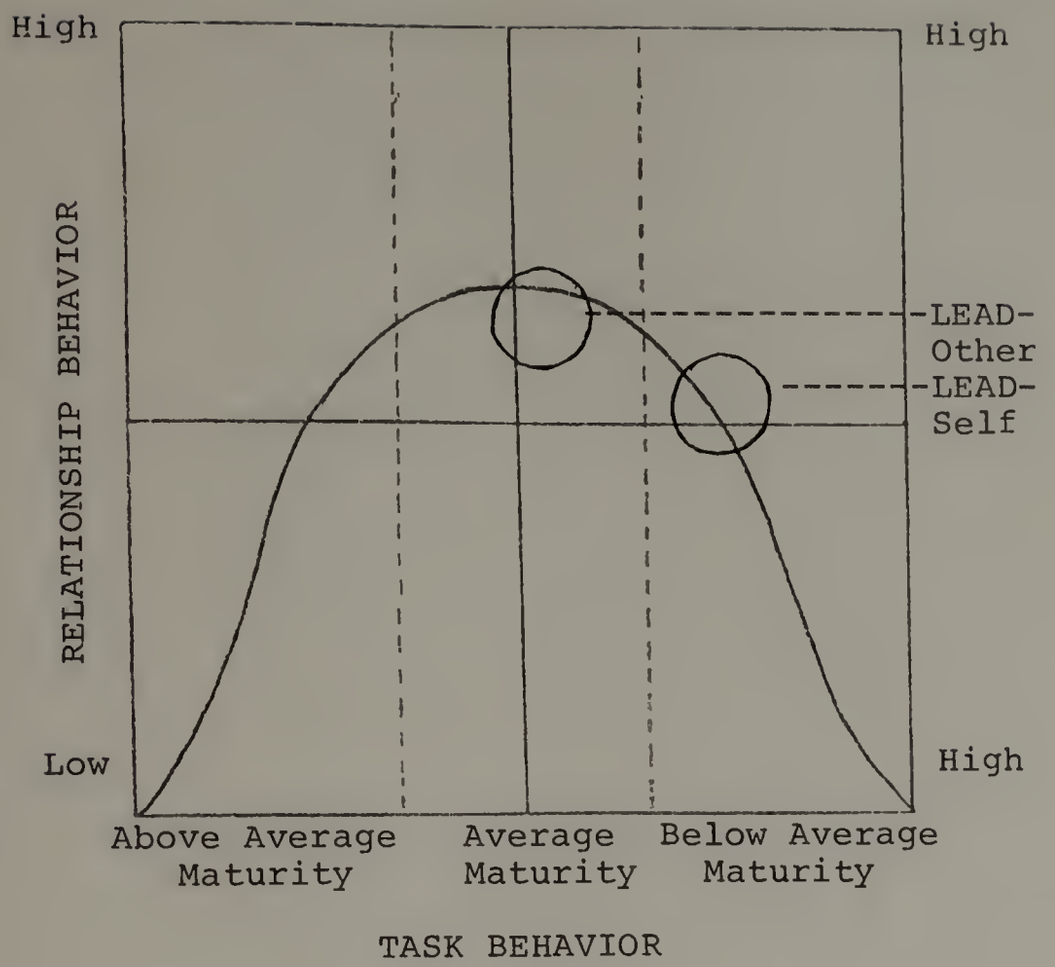

Figure 6. LEAD-Self and LEAD-Other Dominant and Supportive Style Scores for Head Nurses in Agency A

Adapted from Hersey, P. and Blanchard, K. H. Management of Organizational Behavior, (2nd. ed.). Englewood Cliffs, N.J.: Prentice-Hall, 1972.

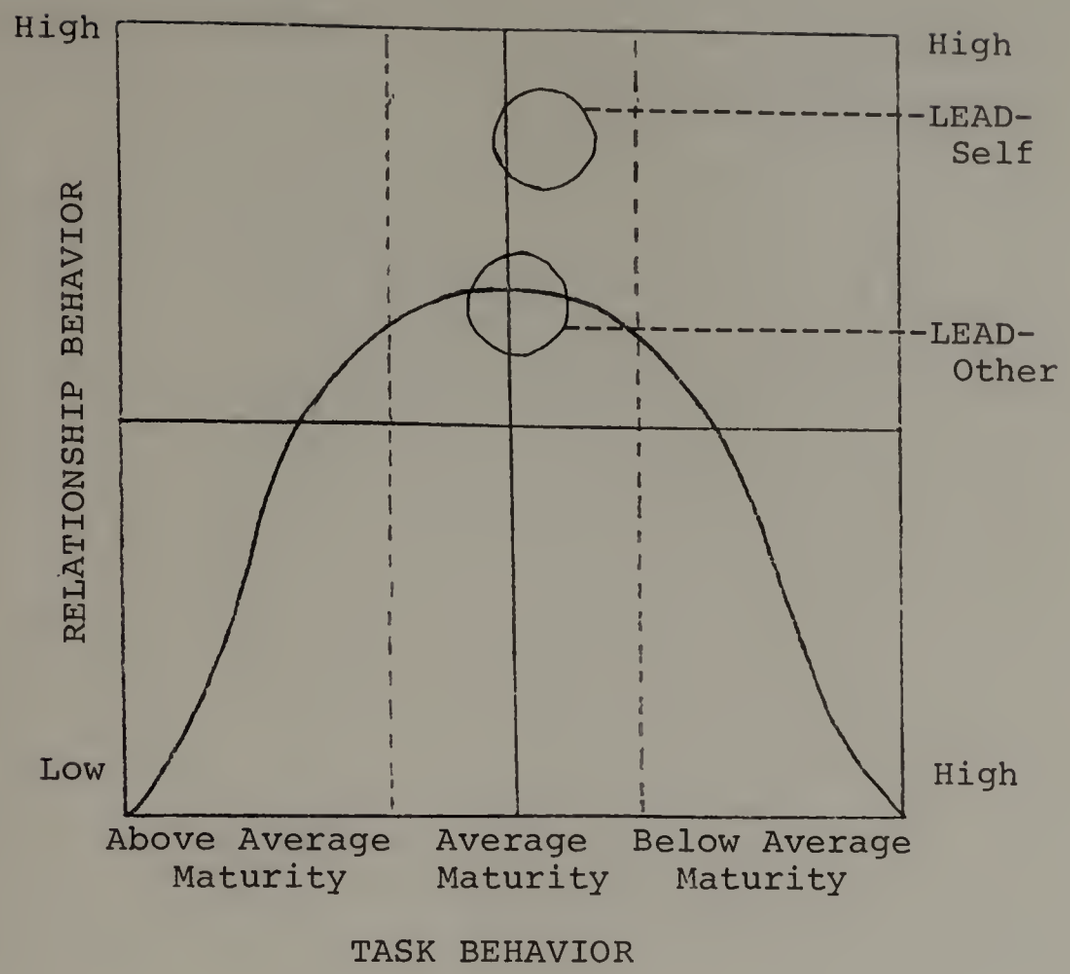

Figure 7. LEAD-Self and LEAD-Other Dominant and Supportive Style Scores for Head Nurses in Agency B

Adapted from Hersey, P. and Blanchard, K. H. Management of Organizational Behavior, (2nd. ed.). Englewood Cliffs, N.J.: Prentice-Hall, 1972.

the Head Nurses tended to select the appropriate leadership style for the given situation somewhat more frequently than did their staff.

The Leadership Effectiveness Rating Form scores are given in Table 3. The mean scores reflect a possible range of 1 to 7 on each dimension of the scale. The Nursing Supervisors scored the Head Nurses higher on every scale dimension than did the Nursing Staff. The Nursing Supervisors viewed the Head Nurses as most effective in maintaining channels of Communication followed by Overall Effectiveness and Delegation of Responsibility. The lowest score is given for Planning of Nursing Care.

The Nursing Staff tended to score the Head Nurses as more effective in delegating responsibilities and in providing adequate supervision than in maintaining channels of Communication and Overall Effectiveness. The lowest score was also given for the Head Nurses in providing assistance in Planning Nursing Care. The highest score, with the smallest deviation, for the Nursing Staff was their own score for Job Satisfaction.

Analysis of Variance

In order to determine if the Head Nurses within agencies differed in their leadership styles as perceived by subordinates, the Consideration and Initiating Structure scores from the LBDQ were subjected to one-way analysis of variance. Significant

TABLE 3

MEANS AND STANDARD DEVIATIONS ON LEADERSHIP EFFECTIVENESS RATING FORM FOR HEAD NURSES

Leadership Effectiveness Rating Form	Agency A		Agency B		Combined	
	Mean	S.D.	Mean	S.D.	Mean	S.D.
Subordinates						
Overall Effectiveness	4.87	1.83	4.88	1.40	4.88	1.57
Planning Nursing Care	4.84	1.95	4.48	1.58	4.62	1.74
Supervision	5.13	1.91	5.13	1.61	5.13	1.72
Communication	4.77	2.18	5.02	1.71	4.92	1.90
Delegation	5.26	1.81	5.34	1.30	5.31	1.51
Overall Job Satisfaction	5.52	1.55	5.21	1.43	5.33	1.49
Superiors						
Overall Effectiveness	5.46	.93	5.28	1.10	5.36	1.01
Planning Nursing Care	5.67	.98	4.74	1.16	5.16	1.16
Supervision	5.53	1.50	5.02	1.07	5.25	1.28
Communication	5.73	1.01	5.46	1.15	5.59	1.07
Delegation	4.97	.81	5.67	.76	5.35	.84

F ratios in Table 4 indicate that there was agreement among the subordinates in describing their Head Nurse and that the descriptions of the Head Nurses differed significantly in both agencies. It was noted in the previous section that the mean scores for Structure and Consideration on the LBDQ were similar in each agency. This is confirmed in Table 4, where the F ratios between agencies are not significant.

An analysis of variance on the LEAD-Other showed similar results, in general, as the LBDQ but are not represented here because the results are not germane to the study. Since the scores on the instrument are not independent of each other, once the variance of one score is known, one knows about the variance of the other scores. The analysis of variance indicates that the Nursing Staff do agree on their description of Head Nurses on the LEAD instrument, and that the Head Nurses do differ in their dominant leadership style scores on the LEAD-Other instrument (see Appendix K for summary of LEAD-Other analysis of variance).

Because the F ratios for the LBDQ were large enough to be significant, the investigator could proceed with computation of the correlations in order to test the specific hypotheses. The reader is reminded that although the hypothese are stated in terms of congruency, the hypotheses were tested after first computing discrepancy scores (D-scores).

TABLE 4

SUMMARY OF ANALYSIS OF VARIANCE FOR LBDQ

Scores	df	F	p
Structure			
Agency A	9/52	4.33	.001
Agency B	11/84	5.70	.001
Between Agencies	1/156	.45	.505
Consideration			
Agency A	9/52	7.71	.001
Agency B	11/84	3.45	.001
Between Agencies	1/156	1.26	.264

Hypothesis 1

The first hypothesis predicted that there would be a positive relationship between the self concept and the congruency between the LOQ and the LBDQ. Table 5 gives the Pearson product moment coefficients for the Head Nurses in Agency A, Agency B and as a combined group

TABLE 5

CORRELATIONS BETWEEN TOTAL POSITIVE SELF ESTEEM SCORE AND CONGRUENCY BETWEEN LOQ AND LBDQ - Hypothesis 1

Discrepancy Between LOQ and LBDQ	Total Positive Score		
	Agency A	Agency B	Combined
Structure	-.60*	.07	-.29
Consideration	-.63*	.01	-.24

* $p < .05$

The hypothesis is partially supported. The correlations, which are large enough to be significant at the .05 level, indicate that the greater the congruency between Consideration and Initiating Structure scores for the Head Nurses in Agency A the higher the Total Positive Self Esteem scores. (The correlation is negative in Table 5 because congruency is actually measured by a discrepancy score.) There is no significant correlation shown between the congruency of LOQ and LBDQ scores and self concept of Head Nurses in Agency B. The correlations for the combined group are in the direction predicted but not significant.

Hypothesis 2

The second hypothesis predicted that the self concept would be positively related to the congruency between the leadership style scores on the LEAD-Self and the leadership style scores by subordinates on the LEAD-Other. Correlations testing this hypothesis are found in Table 6 for Head Nurses in each agency and as a combined group.

TABLE 6

CORRELATIONS BETWEEN TOTAL POSITIVE SELF ESTEEM SCORE AND CONGRUENCY BETWEEN LEAD-SELF AND LEAD-OTHER HYPOTHESIS 2

Discrepancy Between LEAD-Self and LEAD-Other	Total Positive Score		
	Agency		
	A	B	Combined
H.T., L.R.	.06	-.15	-.06
H.T., H.R.	-.52	-.44	-.46*
H.R., L.T.	.01	.13	.10
L.T., L.R.	-.64*	-.32	-.47*
Effectiveness Score	.03	-.22	-.12

* $p < .05$

Only the combined congruency between the LEAD-Self and LEAD-Other dimensions of High Task/High Relationship and Low Task/Low Relationship are significantly related to the Total Positive Self Esteem scores. The two correlations of -.46 and -.47 indicate that the greater the discrepancy between LEAD-Self and LEAD-Other scores of Quadrants 2 and 4, the lower the Head Nurse's self concept as evidenced by the Total-Positive score on the TSCS. For two leadership style quadrants that are complementary then, it was found that the more congruent the views of Head Nurse and her Nursing Staff, the more positive was the Head Nurse's self concept. The individual agency correlations on those two

dimensions are in the predicted direction, but are not significant at the .05 level. The hypothesis is partially supported for two dimensions of the Leader Effectiveness and Adaptability Description instrument.

Hypothesis 3A

Hypothesis 3A predicts that the congruency between scores on the LOQ and LBDQ will be positively related to the Leadership Effectiveness Rating Form Scores (ERS) of superiors. The correlations between congruency and ERS scores for Head Nurses in each agency and as a combined group, as perceived by superiors, are given in Table 7.

The hypothesis is partially supported for the Head Nurses in Agency A. The Overall Effectiveness score, the Planning of Nursing Care score, and the Supervision score are negatively related to both Structure and Consideration discrepancy scores between the LOQ and LBDQ. The correlations indicate that the more discrepant the Structure and Consideration scores, the lower the effectiveness scores in the three dimensions, as viewed by the superiors. There are no significant relationships shown for Head Nurses in Agency B.

As a combined group, all correlations, with the exception of the Delegation score, are in the direction predicted, but do not come close to the .05 level of significance expected. Hypothesis 3A is supported, for some effectiveness

dimensions, for Head Nurses in Agency A but not for Head Nurses in Agency B.

TABLE 7

CORRELATIONS BETWEEN CONGRUENCY OF LOQ AND LBDQ SCORES AND LEADER RATED EFFECTIVENESS OF SUPERIORS - HYPOTHESIS 3A

ERS Superiors	Discrepancy LOQ - LBDQ					
	Structure			Consideration		
	Agency A	Agency B	Combined	Agency A	Agency B	Combined
Overall Effectiveness	-.67*	0	-.29	-.55*	.09	-.20
Planning Nursing Care	-.74**	-.08	-.29	-.68**	.18	-.16
Supervision	-.61*	-.02	-.31	-.58*	.24	-.22
Communication	-.43	-.03	-.16	-.25	.07	-.07
Delegation	.16	-.03	0	.23	.06	.09

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

Hypothesis 3B

Hypothesis 3B predicts that the congruency between scores on the LOQ and LBDQ will be positively related to the Leadership Effectiveness Rating Form Scores (ERS) of subordinates of the Head Nurse. Table 8 shows the correlations between the congruency and ERS scores for Head Nurses in each agency and as a combined group as perceived by the subordinates.

The correlations between the six dimensions measured on the Leadership Effectiveness Rating Form and the congruency between the LOQ and LBDQ Initiating Structure scores support the hypothesis for subordinates in Agency A for each of the six dimensions on the ERS. In Agency B, there is a significant correlation between the congruency and the effectiveness dimension of Supervision. The correlations between congruency and the other five effectiveness dimensions are in the direction predicted but are not significant. Correlations for the combined group are significant at the .01 level between congruency and the dimensions of Overall Effectiveness, Planning Nursing Care, Supervision, Communication, and Overall Job Satisfaction. The correlation between congruency and the ERS dimension of Delegation is at the .05 level of significance.

Correlations are significant between five of the six effectiveness dimensions and the congruency between the LOQ and LBDQ Consideration scores for Head Nurses in Agency A. Only Delegation does not correlate significantly. In Agency B, the dimensions of Communication and Delegation show significant relationships ($p < .05$) with the Consideration congruency scores. The combined subordinate's correlation between each of the six dimensions of the ERS and the congruency between the LOQ and LBDQ Consideration scores are significant at the .01 level for five of the six dimensions.

TABLE 8

CORRELATIONS BETWEEN CONGRUENCE OF LOQ AND LBDQ SCORES AND LEADERSHIP EFFECTIVENESS RATING FORM (ERS) SCORES FOR SUBORDINATES - HYPOTHESIS 3B

	LOQ-LBDQ					
	Structure			Consideration		
	Agency A	Agency B	Combined	Agency A	Agency B	Combined
ERS - Subordinates						
Overall Effectiveness Score	-.92**	-.45	-.72**	-.81**	-.27	-.59**
Planning Nursing Care	-.83**	-.59*	-.69**	-.70*	-.25	-.51**
Supervision	-.77**	-.51*	-.64**	-.65*	-.31	-.50**
Communication	-.82**	-.30	-.63**	-.69*	-.57*	-.64**
Delegation	-.57*	-.25	-.44**	-.50	-.56*	-.51**
Overall Job Satisfaction	-.69*	-.42	-.52**	-.56*	-.41	-.46*

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

They include Overall Effectiveness, Planning Nursing Care, Supervision, Communication and Delegation. The correlation for the sixth dimension, Overall Job Satisfaction is significant at the .05 level. Hypothesis 3B, because the data on the LBDQ and ERS came from the same respondents, is the easiest to support.

The correlations indicate that the greater the congrency between the Structure and Consideration scores for Head Nurses and their Nursing Staff, the higher the effectiveness scores and job satisfaction for the Nursing Staff. Hypothesis 3B is supported.

Hypothesis 4A

The fourth hypothesis states that the congruency between scores on the LEAD-Self and the LEAD-Other will be positively related to the Leadership Effectiveness Rating Form scores of superiors. Pearson product moment correlations are given in Table 9 for superiors.

TABLE 9

CORRELATIONS BETWEEN CONGRUENCY OF LEAD-SELF AND LEAD-OTHER SCORES AND LEADERSHIP EFFECTIVENESS RATING FORM (ERS) SUPERIORS - HYPOTHESIS 4A

Variable	Discrepancy Between LEAD-Self and LEAD-Other					
	HT, LR			HT, HR		
	Agency A	Agency B	Combined	Agency A	Agency B	Combined
ERS - Superiors						
Overall Effectiveness Score	.37	.41	.38	-.53	-.20	-.34
Planning						
Nursing Care	.51	.48	.41	-.68*	-.02	-.30
Supervision	.44	.53*	.44*	-.55*	-.16	-.37*
Communication	.28	.13	.17	-.47	-.48*	-.50
Delegation	-.50	.48	.09	.22	-.20	-.03

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

TABLE 9 CONTINUED

CORRELATIONS BETWEEN CONGRUENCY OF LEAD-SELF AND LEAD-OTHER SCORES AND LEADERSHIP EFFECTIVENESS RATING FORM (ERS) SUPERIORS - HYPOTHESIS 4A

Discrepancy Between LEAD-Self and LEAD-Other					
HR, LT			LT, LR		
Agency A	Agency B	Combined	Agency A	Agency B	Combined
-.30	.14	-.06	-.77*	-.42	.54**
-.35	.08	-.19	-.78**	-.14	-.37*
-.26	.21	-.09	-.64*	-.38*	-.51**
-.50	.17	-.13	-.76**	-.31	-.51**
.10	.25	.27	.06	-.41	-.14

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

As can be seen in the table, the correlations indicate that the Overall Effectiveness score relates significantly, in the direction predicted, for only one of the four possible leadership styles on the LEAD instrument--the Low Task/Low Relationship quadrant. As a combined group, the correlations are significant between the Low Task/Low Relationship quadrant and four of the five scores on the Leadership Effectiveness Rating Form, with Delegation being the exception. Again, the correlations for congruency scores for the dimensions of High Relationship/Low Task and High Task/High Relationship are in the direction predicted for four of the effectiveness scores but are not significant for the combined group. The correlations suggest that the more congruent the scores for these two leadership style dimensions the higher the effectiveness scores for Overall Effectiveness, Planning Nursing Care, Supervision and Communication.

The High Task/Low Relationship quadrant congruency scores, with the exception of the one Delegation correlation in Agency A, show a relationship in the direction not predicted by the hypothesis. These correlations would suggest that the greater the discrepancy between the High Task/Low Relationship scores the higher the scores for effectiveness as perceived by supervisors.

The Hypothesis is partially supported for congruency on the Low Task/Low Relationship dimension correlation with four of the effectiveness scores.

Hypothesis 4B

Hypothesis 4B predicts that the congruency between scores on the LEAD-Self and LEAD-Other will be positively related to the Leadership Effectiveness Rating Form Scores of subordinates of the Head Nurses. Table 10 depicts the correlations for the testing of this hypothesis.

TABLE 10

CORRELATIONS BETWEEN CONGRUENCY OF LEAD-SELF AND LEAD-OTHER SCORES AND LEADERSHIP EFFECTIVENESS RATING FORM (ERS) SUBORDINATES - HYPOTHESIS 4B

Variable	Discrepancy Between LEAD-Self and LEAD-Other					
	HT, LR			HT, HR		
	Agency A	Agency B	Combined	Agency A	Agency B	Combined
ERS - Subordinates						
Overall Effectiveness Score	.09	.04	.06	-.61*	-.69**	-.64**
Planning						
Nursing Care	.15	-.07	.03	-.62*	-.65**	-.61**
Supervision	.02	.06	.04	-.54	-.79**	-.66**
Communication	.35	-.53*	-.01	-.70*	-.50*	-.59**
Delegation	.53	-.57*	.02	-.70*	-.65*	-.66**
Overall Job Satisfaction	.39	-.36	.02	-.67*	-.84**	-.70**

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

TABLE 10 CONTINUED

CORRELATIONS BETWEEN CONGRUENCY OF LEAD-SELF AND LEAD-OTHER SCORES AND LEADERSHIP EFFECTIVENESS RATING FORM (ERS) SUBORDINATES - HYPOTHESIS 4B

Discrepancy Between LEAD-Self and LEAD-Other					
HR, LT			LT, LR		
Agency A	Agency B	Combined	Agency A	Agency B	Combined
-.01	.42	.18	-.87**	-.85**	-.84**
-.16	.30	-.02	-.88**	-.79**	-.80**
-.13	.42	.13	-.87**	-.85**	-.82**
-.33	-.04	-.18	-.92**	-.42	-.81**
-.52	-.36	-.42	-.82**	-.49	-.72**
-.48	-.01	-.33	-.90**	-.62*	-.75**

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

The correlations indicate significant relationships in the direction predicted between congruency on the leadership styles of High Task/High Relationship and Low Task/Low Relationship and all effectiveness scores for subordinates. The more congruent the perceptions of Head Nurses and their Nursing Staff on the leadership style dimensions of High Task/High Relationship and Low Task/Low Relationship, the more effective the Head Nurse is viewed to be by the subordinates as well as the more job satisfaction the subordinates say they have.

The hypothesis is partially supported for two of the four leadership style quadrant congruency scores and subordinates' effectiveness rating scores for Head Nurses in both agencies. The correlations for the High Task/Low Relationship and High Relationship/Low Task congruency scores and subordinate's effectiveness rating scores are weak, inconsistent and for the first quadrant, are in the direction that was not predicted by the hypothesis. The same is true for the Overall Effectiveness score and the congruency on the High Relationship/Low Task leadership style on the LEAD-instrument. The correlations would suggest that the less congruent the scores on the High Task/Low Relationship quadrant, the higher the effectiveness rating for all dimensions except Communication in the combined

group. Hypothesis 4B is supported for two leadership style dimensions (HT, HR; LT, LR) on the LEAD instrument.

Hypothesis 5

Hypothesis 5 predicts that the relationship between the Initiating Structure and Consideration scores on the Leader Opinion Questionnaire-Ohio State Model and the same scores on the Leader Behavior Description Questionnaire will be positive. This hypothesis tests the relationship of self and other perceived leadership styles as measured by the LOQ and LBDQ. Table 11 depicts the correlations for this hypothesis.

TABLE 11

CORRELATIONS BETWEEN STRUCTURE AND CONSIDERATION SCORES ON LOQ AND LBDQ - HYPOTHESIS 5

LOQ	LBDQ					
	Structure			Consideration		
	Agency A	Agency B	Combined	Agency A	Agency B	Combined
Structure	-.33	0	-.17			
Consideration				.03	.22	.13

The correlations between Structure scores on the LOQ and LBDQ in Agency A, although not significant, are in the wrong direction than that expected. The Head Nurse who views

herself as high on Structure tends to be viewed by her staff as low on Structure and vice versa. The combined group correlation for Structure is also negative but not significant.

The correlations for the dimension of Consideration on the LOQ and LBDQ are positive, but again, not significant. Hypothesis 5 is not supported. This indicates that subordinates do not agree with their Head Nurse's perception of her own leadership style.

Hypothesis 6

The sixth hypothesis predicts that the four quadrant leadership style scores and the effectiveness scores on the LEAD-Self will be positively related to the respective leadership style scores and effectiveness scores, as perceived by subordinates, on the LEAD-Other. Pearson product moment coefficients of correlation (Table 12) were computed to test this hypothesis.

The correlations show only one significant realtionship ($p < .05$) between the Head Nurse's perception of self as leader and the follower's perception of the Head Nurse as indicated by scores on the LEAD instruments. There is a significant correlation of .65 between the Low Task/Low Relationship leadership style quadrants as perceived by the Head Nurses and their subordinates in Agency A.

The leadership style scores on the LEAD instruments, as perceived by self and others, are not correlated significantly although the correlations for Agency A are in the direction

TABLE 12

CORRELATIONS BETWEEN LEAD-SELF AND LEAD-OTHER QUADRANT SCORES AND EFFECTIVENESS SCORE - HYPOTHESIS 6

LEAD-Other	LEAD-SELF					
	H.T., L.R.			H.T., H.R.		
	Agency A	Agency B	Combined	Agency A	Agency B	Combined
H.T., L.R.	.21	-.04	-.11	.24	-.16	.08
H.T., H.R.						
H.R., L.T.						
L.T., L.R.						
Effectiveness Score						

* $p < .05$

TABLE 12 CONTINUED

CORRELATIONS BETWEEN LEAD-SELF AND LEAD-OTHER QUADRANT SCORES AND EFFECTIVENESS SCORE - HYPOTHESIS 6

LEAD-SELF								
H.R., L.T.			L.T., L.R.			Effectiveness Score		
Agency A	Agency B	Combined	Agency A	Agency B	Combined	Agency A	Agency B	Combined
.25	.28	.24	.65*	-.27	.18	.02	-.21	-.10

* $p < .05$

predicted. In Agency B, the correlations are not significant and are negative for three of the four leadership style quadrant scores as well as the effectiveness score. On the LEAD instruments, as on the LOQ and LBDQ, the subordinates do not agree with the Head Nurse's perception of her own leadership styles nor do they agree with her own effectiveness score. Hypothesis 6 is not supported.

Hypothesis 7

The seventh hypothesis predicts that the Initiating Structure and Consideration scores on the LOQ will be positively related to the dominant leadership style scores of Task and Relationship Behavior found on the LEAD-Self. Table 13 gives the Pearson product moment correlation coefficients which test this hypothesis.

Only two correlations in Table 13 support the hypothesis. The correlations between the High Relationship/Low Task leadership style and the LOQ dimension of Consideration for Head Nurses in Agency B and as a combined group are significant at the .01 level. One would expect there to be positive correlations between the Consideration dimension and the leadership style quadrants that include High Relationship. Similarly, one would expect positive correlation between Structure scores and leadership style scores that included High Task. Those leadership style scores that include Low Task or Low Relationship should correlate negatively with the

Structure and Consideration scores, respectively. As the correlations in Table 13 indicate, this is not the case. In Agency A the correlations between Structure and High Task/Low Relationship indicate that if the scores are high on Structure they are low for High Task/Low Relationship. In Agency A, there is also a positive and significant relationship between Structure scores and Low Task/Low Relationship leadership style that is opposite of the relationship predicted or expected. In Agency B, there is a positive relationship between Structure scores and leadership style of High Relationship/Low Task which, also, is not the relationship predicted. This would indicate that Head Nurses who viewed themselves as being high on Structure do not see themselves as having a high High Task/Low Relationship score. They do, however, view themselves as having higher scores in the Low Task/Low Relationship leadership quadrant. These findings indicate that the Head Nurses were inconsistent in viewing their own leadership styles on two instruments that were based on similar definitions of leadership behaviors.

In addition to the correlations previously discussed for Consideration scores, only the correlations between Consideration and the High Task/Low Relationship leadership style scores are in the direction predicted, although not significant.

TABLE 13

CORRELATIONS BETWEEN STRUCTURE AND CONSIDERATION SCORES ON LOQ AND QUADRANT SCORES ON LEAD-SELF - HYPOTHESIS 7

Variable	LOQ					
	Structure			Consideration		
	Agency A	Agency B	Combined	Agency A	Agency B	Combined
LEAD-Self						
HT, LR	-.67	-.02	-.30	-.50	-.25	-.24
HT, HR	.42	-.41	.03	.07	-.41	-.24
HR, LT	-.05	.66**	.24	.33	.93**	.61**
LT, LR	.68*	-.13	.22	.39	-.05	.07

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

The correlations tend to indicate that the Head Nurses are not consistent in viewing their own leadership styles on the LOQ and LEAD-Self instruments, instruments based on similar definitions of leadership behaviors. Hypothesis 7 is not supported.

Because the scores on the LEAD-Self instrument are not independent of each other, any significant correlation between the Structure and Consideration scores on the LOQ and any one of the LEAD-Self leadership style quadrants will make it less likely that there will be additional correlations with any of the other quadrants. An additional computation was done, therefore, to further test Hypothesis 7. The Structure and

Consideration scores were combined for the LOQ, thus allowing correlations to be computed between the LOQ and LEAD-Self scores. The Structure score was then correlated with the High Task/Low Relationship leadership style score, as before. The Consideration score was correlated with the High Relationship/Low Task leadership style score, also as before. The combined Structure/Consideration score was correlated with both the High Task/High Relationship quadrant and the Low Task/Low Relationship quadrant since these two quadrants combine Task and Relationship behaviors. Table 14 presents the correlational data of the further testing of Hypothesis 7.

TABLE 14

CORRELATIONS BETWEEN STRUCTURE, CONSIDERATION AND COMBINED STRUCTURE/CONSIDERATION SCORES ON LOQ AND QUADRANT SCORES ON LEAD-SELF - HYPOTHESIS 7

	L O Q								
	Structure Score			Consideration Score			Combined Structure/ Consideration Score		
	Agency A	Agency B	Combined	Agency A	Agency B	Combined	Agency A	Agency B	Combined
LEAD-Self									
H.T., L.R.	-.67*	.02	-.30						
H.T., H.R.							.29	-.45	-.12
H.R., L.T.				.33	.92**	.61**			
L.T., L.R.							.62*	-.09	.16

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

Again, the only significantly positive relationship is to be found between the Consideration score and the High Relationship/Low Task leadership style. The combined Structure/Consideration score shows correlations that are inconsistent between agencies, and the significant positive relationship in Agency A between Consideration and the Low Task/Low Relationship leadership style quadrant is in the wrong direction than that expected. Hypothesis 7 is not supported by this additional computation.

Hypothesis 8

Hypothesis 8 predicts that the Initiating Structure and Consideration scores on the LBDQ will be positively related to the dominant leadership style scores of Task and Relationship Behaviors on the LEAD-Other instrument. The results of the correlational studies are given in Table 15.

TABLE 15

CORRELATIONS BETWEEN STRUCTURE AND CONSIDERATION SCORES ON LBDQ AND QUADRANT SCORES ON LEAD-OTHER - HYPOTHESIS 8

LEAD-Other	LBDQ					
	Structure			Consideration		
	Agency A	Agency B	Combined	Agency A	Agency B	Combined
H.T., L.R.	.12	.69**	.53**	-.16	-.55*	-.36*
H.T., H.R.	.89**	.49	.67**	.86**	.39	.70**
H.R., L.T.	-.01	-.67**	-.41*	.38	.56*	.46*
L.T., L.R.	-.85**	-.76**	-.73**	-.95**	-.31	-.75**

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

As can be seen in Table 15, the correlations between both Structure scores, Consideration scores and two leadership style quadrants is significant ($p < .01$) in Agency A. The correlations indicate that high scores on Structure and Consideration show similar high scores on the High Task/High Relationship quadrant. The reverse is true for the relationship of Structure and Consideration scores to the Low Task/Low Relationship leadership style quadrant scores. Thus, if there were high scores for Structure and Consideration on the LBDQ, then there were low scores on the Low Task/Low Relationship leadership quadrant, which is what was expected.

In Agency B, significant relationships (p .01) were shown between Structure and the High Task/Low Relationship leadership quadrant score, the High Relationship/Low Task leadership quadrant score and the Low Task/Low Relationship leadership quadrant scores. The Consideration score correlated significantly ($p < .05$) with the two leadership quadrant scores of High Task/Low Relationship and High Relationship/Low Task.

The significant relationships in each agency were as expected. The Structure scores correlated positively with at least one quadrant that is a High Task quadrant and correlate negatively with at least one quadrant that is a Low Task quadrant. Similarly, the Consideration scores correlate positively with the quadrants that are High Relationship oriented. The scores correlate negatively with the quadrants that are Low Relationship quadrants.

The correlations for the combined agency scores are statistically significant ($p < .05$, $p < .01$) and in the direction predicted in the hypothesis. The High Task/Low Relationship leadership style scores correlate positively with Structure and negatively with Consideration. The High Task/High Relationship leadership style scores correlate positively with both Structure and Consideration. The High Relationship/Low Task leadership style scores correlate negatively with both Structure and Consideration scores. This

indicates that the Nursing Staff are consistent in describing their Head Nurse's leadership style behaviors on the two instruments based on similar definitions of leadership behaviors. Hypothesis 8 is supported.

Further correlations were computed based on combined Structure/Consideration scores and two leadership style quadrants on the LEAD-Other. As previously discussed under Hypothesis 7, the lack of independence of the LEAD instrument scores could influence correlations if any one of the quadrant scores correlated with another variable. Additional correlations (Table 16) were computed between Structure scores and High Task/Low Relationship scores, Consideration scores and High Relationship/Low Task scores and combined Structure/Consideration scores and High Task/High Relationship scores and Low Task/Low Relationship scores.

Although the Structure and Consideration index score correlations for Agency A are not significant, they are in the direction predicted. All other correlations are in the direction predicted and are statistically significant ($p < .05$). The Structure score is positively related to the High Task/Low Relationship leadership style scores, and the Consideration score is positively related to the High Relationship/Low Task leadership style scores. The combined Structure/Consideration scores are positively related to the High Task/High Relationship scores and negatively related to the Low Task/Low Relationship scores with the correlations being extremely high in Agency A and thus, questionable.

TABLE 16

CORRELATIONS BETWEEN STRUCTURE, CONSIDERATION AND COMBINED STRUCTURE/CONSIDERATION SCORES ON LBDQ AND QUADRANT SCORES ON LEAD-OTHER - HYPOTHESIS 8

LEAD-Other	L B D Q								
	Structure			Consideration			Combined Structure/ Consideration		
	Agency A	Agency B	Combined	Agency A	Agency B	Combined	Agency A	Agency B	Combined
H.T., L.R.	.12	.69**	.53**						
H.T., H.R.							.92**	.62*	.83**
H.R., L.T.				.38	.56*	.46*			
L.T., L.R.							-.96**	-.78**	-.88**

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

The consistency between the subordinate's perceptions of the Head Nurses on the LBDQ and LEAD-Other instruments are further confirmed by this additional testing of the hypothesis. Hypothesis 8 is supported.

The relationships indicated by the data from Head Nurses and Nursing Staff for Hypotheses 5 through 8 are graphically depicted in Figures 8 and 9.

As Figure 8 shows, in Agency A there is some discrepancy between the Head Nurses' and Nursing Staffs' views of leadership style on the LOQ, LBDQ and LEAD instruments. The discrepancy between the Head Nurses own views of her leadership style is also shown. The consistency between the two instruments for the Nursing Staff is obvious.

Figure 9 depicts an even larger discrepancy between the Head Nurses views of her own leadership style on the two instruments. There is also less consistency between the Nursing Staffs' perceptions of the Head Nurse's leadership style on the LBDQ and LEAD-Other.

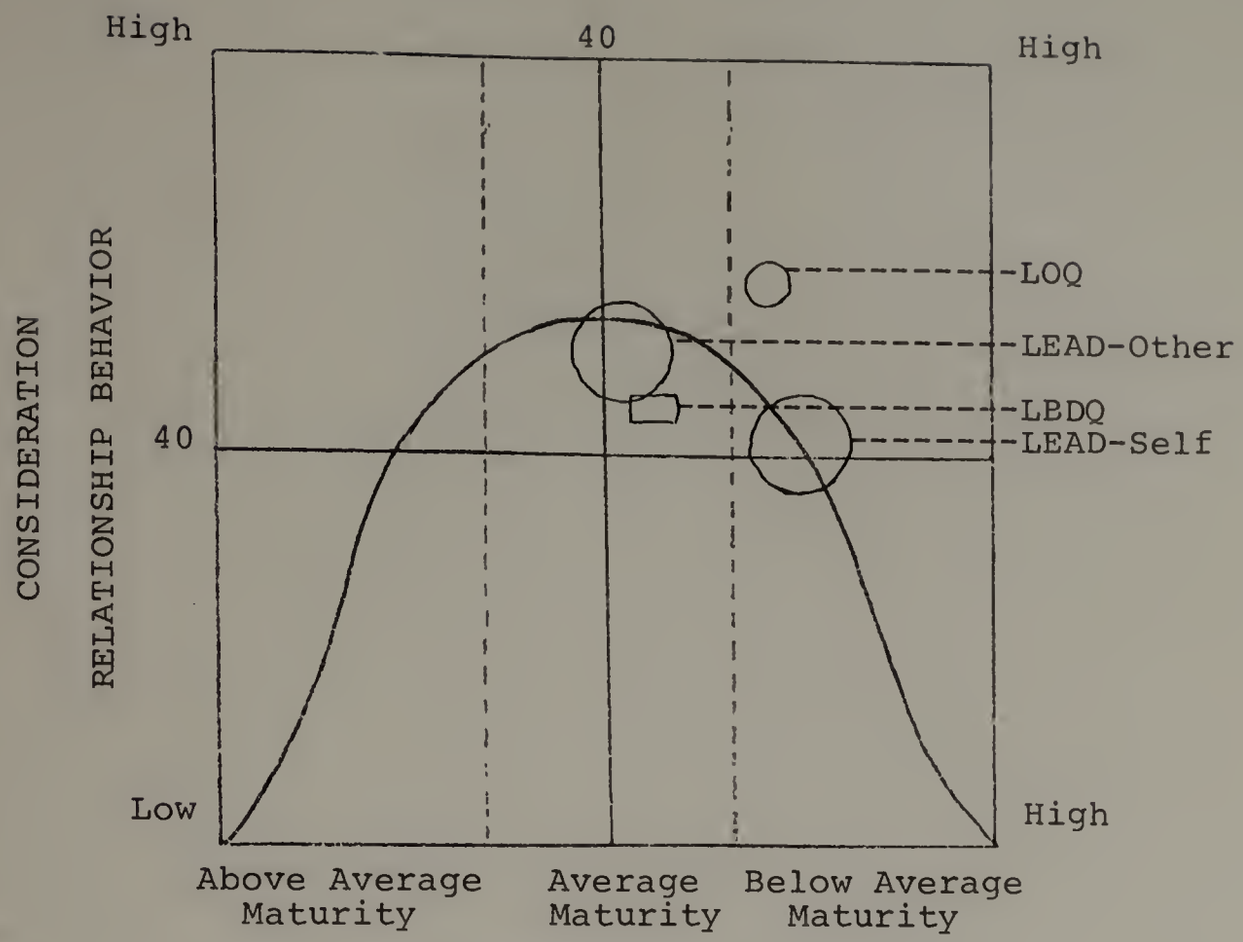

Figure 8. LOQ, LBDQ, LEAD-Self and LEAD-Other Scores for Head Nurses in Agency A.

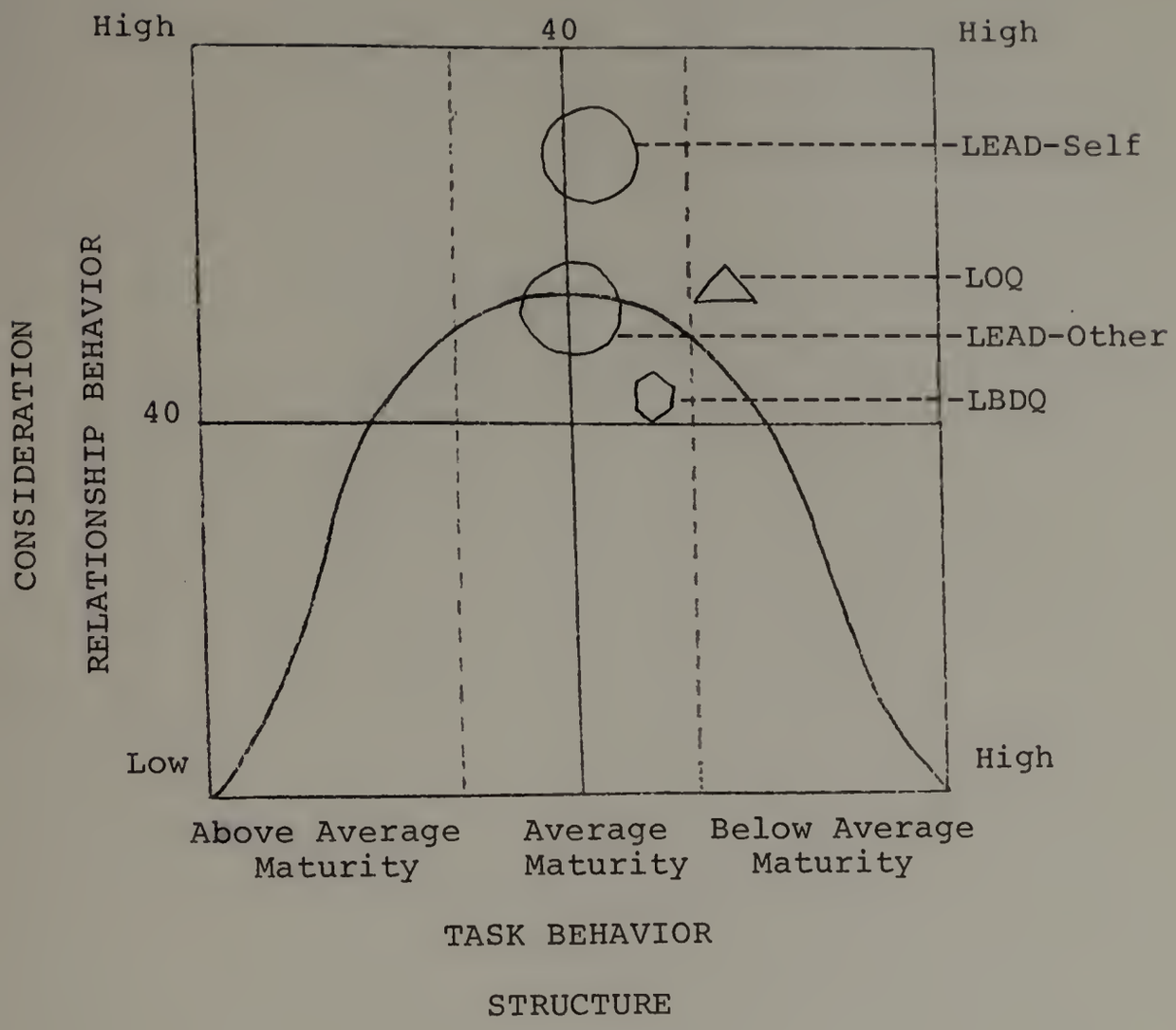

Figure 9. LOQ, LBDQ, LEAD-Self and LEAD-Other Scores for Head Nurses in Agency B.

Hypothesis 9

The final hypothesis predicts that the Leadership Effectiveness Rating Form scores of subordinates will be positively related to the Leadership Effectiveness Rating Form scores of superiors. The Pearson product moment correlations are depicted in Table 17.

In Agency A, there are positive and significant relationships ($p < .05$) between the Leadership Effectiveness Rating Form for superiors and subordinates for Overall Effectiveness, Planning Nursing Care, Supervision, and Communication scores. The dimension of Delegation shows a negative correlation.

In Agency B, although not statistically significant, correlations are in the direction predicted for Overall Effectiveness, Supervision and Communication. Planning Nursing Care and Delegation are negatively correlated.

When Agencies are combined, there are significant relationships ($p < .05$) between the superiors and subordinates for Overall Effectiveness, Supervision and Communication. The correlation for Planning Nursing Care is in the direction predicted although not statistically significant. The Delegation score correlation is negative. The correlations indicate agreement between the superiors' and subordinates' ratings of Head Nurses in the dimensions of Overall Effectiveness, Supervision and Communication. Hypothesis 9 is partially supported.

TABLE 17

CORRELATIONS BETWEEN EFFECTIVENESS RATING FORM SCORES OF SUBORDINATES AND SUPERIORS - HYPOTHESIS 9

ERS - Superiors	ERS - Subordinates					
	Overall Effectiveness			Planning Nursing Care		
	Agency A	Agency B	Combined	Agency A	Agency B	Combined
Overall Effectiveness	.71*	.27	.46*	.68*	-.11	.35
Planning Nursing Care						
Supervision						
Communication						
Delegation						

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

TABLE 17 CONTINUED

CORRELATIONS BETWEEN EFFECTIVENESS RATING FORM SCORES
OF SUBORDINATES AND SUPERIORS - HYPOTHESIS 9

ERS - Subordinates								
Supervision			Communication			Delegation		
Agency A	Agency B	Combined	Agency A	Agency B	Combined	Agency A	Agency B	Combined
.62*	.17	.43*	.78**	.18	.48*	-.33	-.08	-.21

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

Additional Correlational Studies

An additional series of correlations were computed to determine if there were any relationships between the Head Nurses' perceptions of self on the LOQ and LEAD-Self instruments and the effectiveness ratings of either superiors or subordinates. Similar correlational studies were computed for the subordinates' LBDQ and LEAD-Other instrument scores and the effectiveness rating scores of superiors and themselves. Tables 18 through 21 show these results. Tables 18 and 19 will be discussed together, followed by discussion of Tables 20 and 21.

TABLE 18

CORRELATIONS BETWEEN LOQ SCORES AND LEADERSHIP EFFECTIVENESS RATING FORM SCORES FOR SUPERIORS AND SUBORDINATES

	LOQ					
	Structure			Consideration		
	Agency A	Agency B	Combined	Agency A	Agency B	Combined
ERS - Superiors						
Overall Effectiveness Score	-.26	-.07	-.16	.22	-.09	.05
Planning Nursing Care	-.43	-.15	-.26	.09	-.31	-.08
Supervision	-.35	.07	-.20	.06	-.12	.01
Communication	.01	.25	.12	.44	.29	.37
Delegation	.48	-.15	.19	.29	-.32	-.10
ERS -Subordinates						
Overall Effectiveness Score	-.49	-.01	-.32	-.16	.09	-.04
Planning Nursing Care	-.47	-.01	-.32	-.14	.01	-.04
Supervision	-.30	-.05	-.20	.0	-.04	-.02
Communication	-.46	.01	-.33	.07	.19	.10
Delegation	-.35	-.11	-.28	.16	-.23	.0
Overall Job Satisfaction	-.38	.05	-.24	.01	-.11	.0

TABLE 19

CORRELATIONS BETWEEN QUADRANT SCORES ON LEAD-SELF AND LEADERSHIP EFFECTIVENESS RATING FORM SCORES FOR SUPERIORS AND SUBORDINATES

	LEAD-Self Scores					
	HT, LR			HT, HR		
	Agency A	Agency B	Combined	Agency A	Agency B	Combined
ERS - Superiors						
Overall Effectiveness Score	.14	.18	.19	.25	-.09	.01
Planning Nursing Care	.23	.11	.33	.17	.14	.04
Supervision	.24	.23	.29	.11	-.06	-.03
Communication	-.03	.34	.23	.17	-.56	-.30
Delegation	-.60*	.19	-.34	.29	.03	.22
ERS - Subordinates						
Overall Effectiveness Score	.11	.27	.15	.12	-.48	-.17
Planning Nursing Care	.16	.09	.20	.04	-.36	-.17
Supervision	.05	.45	.19	.18	-.51*	-.19
Communication	.12	.31	.13	.16	-.48	-.09
Delegation	.24	.55*	.32	-.02	-.50*	-.23
Overall Job Satisfaction	.26	.72**	.50**	.09	-.61*	-.26

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

TABLE 19 CONTINUED

CORRELATIONS BETWEEN QUADRANT SCORES ON LEAD-SELF AND LEADERSHIP EFFECTIVENESS RATING FORM SCORES FOR SUPERIORS AND SUBORDINATES

LEAD-Self Scores								
HT, LT			LT, LR			Effectiveness Score		
Agency A	Agency B	Combined	Agency A	Agency B	Combined	Agency A	Agency B	Combined
-.31	-.23	-.28	-.45	.30	.06	.07	.17	.11
-.29	-.40	-.41*	-.54*	.11	-.13	-.11	.25	.01
-.25	-.25	-.28	-.42*	.14	-.11	-.28	.12	-.12
-.21	.17	-.01	.05	.50*	.33	-.02	-.08	-.09
.13	-.35	-.02	.46	.15	.28	.29	.08	.24
.05	.16	.05	-.63*	.47	.01	.30	.13	.21
-.07	.14	-.03	-.44	.54*	.04	.08	.33	.13
-.05	0	-.03	-.32	.44	.13	.11	-.01	.03
-.17	.31	.03	-.46	.11	-.14	.07	-.28	-.06
-.15	-.19	-.16	-.25	.57*	.16	-.25	-.18	-.20
-.28	-.10	-.25	-.37	.35	-.03	0	-.32	-.19

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

The general, negative direction of the correlations would tend to indicate that higher effectiveness scores for superiors and subordinates are associated with lower Structure and Consideration scores on the LOQ. The lack of significant correlations tend to indicate that there is no relationship between the Head Nurses' self-perceived leadership style scores on either the LOQ or the LEAD-Self instruments and the Head Nurses' effectiveness ratings as perceived by superiors and subordinates. This suggests that the perception of self as leader is not a significant factor in how effective the leader is viewed by superiors or subordinates. Table 19 also suggests that there is no agreement whatsoever between the effectiveness score on the LEAD-Self and the Leadership Effectiveness Rating Form from either superiors or subordinates of the Head Nurses.

Tables 20 and 21 give the results of the additional correlational studies between the LBDQ and LEAD-Other instrument scores and the Effectiveness Rating Scale scores from superiors and subordinates.

The Head Nurses' Structure and Consideration scores, as combined from both agencies, and as perceived by followers on the LBDQ are positively and significantly related to all dimensions on the Leadership Effectiveness Rating Form for both superiors and subordinates (Table 20). The High Task/ High Relationship leadership style scores on the LEAD-Other

TABLE 20

CORRELATIONS BETWEEN LBDQ SCORES AND LEADERSHIP EFFECTIVENESS RATING FORM SCORES FOR SUPERIORS AND SUBORDINATES

Variable	LBDQ					
	Structure			Consideration		
	Agency A	Agency B	Combined	Agency A	Agency B	Combined
ERS - Superiors						
Overall Effectiveness Score	.79**	.29	.47*	.76**	-.31	.24
Planning Nursing Care	.73**	.28	.37*	.81**	-.58*	.16
Supervision	.59*	.33	.42*	.69*	-.41	.30
Communication	.75**	.20	.40*	.62*	.19	.41*
Delegation	.05	.32	.21	.24	-.59*	-.39*
ERS - Subordinates						
Overall Effectiveness Score	.92**	.72**	.80**	.83**	.44	.68**
Planning Nursing Care	.92**	.79**	.78**	.84**	.38	.69**
Supervision	.91**	.70**	.78**	.80**	.34	.62**
Communication	.90**	.22	.57**	.93**	.96**	.92**
Delegation	.66*	.17	.42*	.81**	.54*	.72**
Overall Job Satisfaction	.88**	.33	.56**	.84**	.54*	.74**

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

TABLE 21

CORRELATIONS BETWEEN QUADRANT SCORES ON LEAD-OTHER AND LEADERSHIP EFFECTIVENESS RATING FORM SCORES FOR SUPERIORS AND SUBORDINATES

Variables	LEAD-OTHER					
	HT, LR			HT, HR		
	Agency A	Agency B	Combined	Agency A	Agency B	Combined
ERS - Superiors						
Overall Effectiveness Score	-.09	.36	.21	.82**	.18	.49**
Planning Nursing Care	-.22	.46	.15	.83**	-.12	.33
Supervision	-.15	.50*	.18	.69*	.04	.46*
Communication	-.38	0	-.11	.63*	.20	.41*
Delegation	-.23	.51*	.36*	-.08	.21	.05
ERS - Subordinates						
Overall Effectiveness Score	.28	.30	.25	.90**	.73**	.84**
Planning Nursing Care	.18	.21	.10	.83**	.69**	.76**
Supervision	.08	.33	.22	.83**	.80**	.80**
Communication	-.14	-.36	-.18	.89**	.55*	.81**
Delegation	-.31	-.34	-.26	.67*	.53*	.63**
Overall Job Satisfaction	.02	-.9	-.11	.79**	.70**	.72**

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

TABLE 21 CONTINUED

CORRELATIONS BETWEEN QUADRANT SCORES ON LEAD-OTHER AND LEADERSHIP EFFECTIVENESS RATING FORM SCORES FOR SUPERIORS AND SUBORDINATES

LEAD-OTHER								
HR, LT			LT, LR			Effectiveness Score		
Agency A	Agency B	Combined	Agency A	Agency B	Combined	Agency A	Agency B	Combined
.04	-.41	-.22	-.77**	-.24	-.48*	.62*	-.42	-.05
.13	-.52*	-.19	-.79**	.07	-.31	.72*	-.46	-.08
.07	-.51	-.18	-.65*	-.16	-.46*	.56*	-.51*	-.01
.41	-.03	.15	-.67*	-.19	-.41*	.80**	-.02	.27
.02	-.67**	-.37*	.13	-.21	-.04	.21	-.48	-.12
-.04	-.34	-.19	-.89**	-.88**	-.85**	.43	.10	.25
.12	-.21	-.01	-.87**	-.83**	-.79**	.51	.13	.28
.11	-.51*	-.20	-.83**	-.82**	-.78**	.61*	.21	.38*
.24	.36	.26	-.91**	-.55**	-.88**	.77**	.52*	.61**
.49	.24	.37*	-.78**	-.42	-.67**	.74**	.23	.47*
.31	-.09	.15	-.87**	-.58*	-.72**	.63*	.53*	.49**

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

(Table 21) are significantly correlated with the subordinate's effectiveness ratings of the Head Nurses while the six dimensions of the Leadership Effectiveness Rating Form are significantly and negatively related to the leadership style of Low Task/Low Relationship on the LEAD-Other instrument.

The Leadership Effectiveness Rating Form scores of superiors for the combined group is positively and significantly related to Structure scores on the LBDQ for Overall Effectiveness, Planning Nursing Care, Supervision and Communication but not for Delegation. The Effectiveness Rating Form scores of superiors is positively correlated with the Consideration scores on the LBDQ for Communication, and negatively correlated with Delegation.

The correlations indicate that the subordinate's rating of effectiveness for the Head Nurses is closely related to the subordinates' perception of the Head Nurses leadership style on the LBDQ and for two of the possible four leadership styles on the LEAD-Other. The higher the Structure and Consideration index scores and the higher the High Task/High Relationship quadrant scores, the more effective is the Head Nurse seen to be by subordinates. The same is indicated for the ratings of Nursing Supervisors, in general. The Head Nurse who is seen as scoring higher on the Low Task/Low Relationship leadership style quadrant is seen as less effective by both Nursing Staff and Nursing Supervisors. The leadership style perceptions of others, then, are more closely related to Effectiveness Ratings than are the self-

perceptions of the Head Nurses to these ratings.

A final series of correlations (Table 22) were computed between the self concept scores of the Head Nurse and each of the effectiveness dimensions of both superiors and subordinates. This was done to test the relationship between positive self concept and the perceived effectiveness of the leader. It was assumed that Head Nurses who had high positive self concepts would be rated as more effective by both superiors and subordinates.

TABLE 22

CORRELATIONS BETWEEN SELF CONCEPT SCORES AND LEADER RATED EFFECTIVENESS OF SUBORDINATES AND SUPERIORS

Leadership Effectiveness Rating Form Scores	Total Positive Self Concept		
	Agency A	Agency B	Combined
Subordinates			
Overall Effectiveness	.52	.40	.45*
Planning Nursing Care	.39	.21	.27
Supervision	.43	.42	.42*
Communication	.45	.49	.44*
Delegation	.28	.30	.27
Overall Job Satisfaction	.41	.74**	.49*
Superiors			
Overall Effectiveness	.49	-.28	.0
Planning Nursing Care	.48	-.59*	-.20
Supervision	.29	-.28	-.01
Communication	.47	.07	.29
Delegation	.29	-.28	-.01

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

As can be seen in Table 22, subordinate's effectiveness dimension scores for their Head Nurses correlate significantly ($p < .01$) for only one dimension - Overall Job Satisfaction for Agency B. The other correlations are in the direction predicted, but are not significant. The Agency A correlations between the effectiveness dimensions and the self concept scores are also in the direction predicted but not significantly so.

When the groups are combined, they are significant ($p < .05$), positive relationship between the self concept scores of the Head Nurses and four effectiveness dimensions. Correlations for Overall Effecitveness, Supervision, Communication and Overall Job Satisfaction show that the more positive the Head Nurses' self concept scores, the more effective she is seen to be by her subordinates on those dimensions.

The correlations from the superiors' effectiveness rating from scores and Head Nurses' self concepts are opposite in each agency. Agency A correlations are in the direction predicted for all five of the effectiveness dimensions. In agency B, however, the correlations between superiors and Head Nurses' self concept scores are generally negative with there being a significant negative relationship of -.59 ($p < .05$) for the dimension of Planning Nursing Care. For Head Nurses in Agency B, then, if they score high on self concept, their supervisors tend to view them as less effective on the effectiveness rating form.

One wonders why there is such a discrepancy between the superiors in Agency B. It may be that Head Nurses who have positive self concepts in some way are viewed as threatening the authority or position of their immediate superior and are therefore rated as less effective. The discrepancy may also represent the fact that the Nursing Supervisors in Agency B do not know the abilities of all of the Head Nurses because they are administratively responsible for only certain Head Nurses. They may, therefore, have less accurate perceptions of the Head Nurses' effectiveness than the supervisors in Agency A who work with each of the Head Nurses in that agency.

Summary of the Results

The purpose of the study was to test certain hypotheses about the assumed relationships among self concept, leadership style and leadership effectiveness as perceived by self and by others. The sample consisted of Head Nurses, Nursing Staff and Nursing Supervisors in two short term, general hospital settings.

Although the hypotheses were stated in terms of congruency, the methodology required the computation of discrepancy scores (D-Scores) between both the Structure and Consideration scores on the LOQ and LBDQ and the leadership quadrant scores on the LEAD-Self and LEAD-Other. Pearson product moment correlation coefficients were then computed to test the relationships predicted in the specific hypotheses.

Hypothesis 1 predicted a positive relationship between the self concept on the one hand and the congruency between the leadership styles on the LOQ and LBDQ on the other. Hypothesis 1 was supported for Head Nurses in Agency A, but not Agency B.

Hypothesis 2 predicted that there would be a positive relationship between the self concept scores of Head Nurses and the congruency between the leadership style scores on the LEAD-Self and LEAD-Other instruments. Hypothesis 2 was partially supported for the High Task/High Relationship and Low Task/Low Relationship leadership styles congruency scores.

Hypothesis 3A predicted that the congruency between the LOQ and LBDQ would be positively related to the Leadership Effectiveness Rating Form scores of superiors. Hypothesis 3A was supported for Head Nurses in Agency A but not for Head Nurses in Agency B.

Hypothesis 3B predicted that there would be a positive relationship between the Leadership Effectiveness Rating Form scores from subordinates and the amount of congruency between the LOQ and LBDQ. Hypothesis 3B was supported for Head Nurses in Agency A and for combined agency scores.

Hypothesis 4A predicted a positive relationship between the Leadership Effectiveness Rating Form scores from superiors and the congruency between the LEAD-Self and LEAD-Other scores. Hypothesis 4A was supported for only the Low Task/Low Relationship leadership style congruency score.

Hypothesis 4B predicted that the congruency between the LEAD-Self and LEAD-Other scores would be positively related to the Leadership Effectiveness Rating Form scores of subordinates. Hypothesis 4B was supported for the High Task/High Relationship and Low Task/Low Relationship leadership style congruency scores.

Hypothesis 5 predicted positive relationships between the Structure and Consideration scores on the LOQ and LBDQ, respectively. Hypothesis 5 was not supported.

Hypothesis 6 predicted that the leadership style and effectiveness scores on the LEAD-Self would be positively related to the respective leadership style and effectiveness scores on the LEAD-Other. Hypothesis 6 was not supported.

Hypothesis 7 predicted a positive relationship between the Initiating Structure and Consideration scores on the LOQ and the dominant leadership style scores for Task and Relationship Behaviors on the LEAD-Self. Hypothesis 7 was not supported.

Hypothesis 8 predicted that the Initiating Structure and Consideration scores on the LBDQ would be positively

related to the dominant leadership style scores of Task and Relationship Behavior on the LEAD-Other. Hypothesis 8 was supported.

Hypothesis 9 predicted a positive relationship between the Leadership Effectiveness Rating Form scores of subordinates and superiors. Hypothesis 9 was partially supported.

Additional correlations were computed to try to determine the direction and strength of relationships between self-perceived leadership style and leadership effectiveness as well as other-perceived leadership style and leadership effectiveness. There were no significant relationships between self-perceived leadership style and superior and subordinate effectiveness rating form scores for Head Nurses. Significant relationships were found between other-perceived leadership style and superior and subordinate effectiveness rating form scores.

This chapter has presented the results of the study in statistical form. Some discussion of the analyses of data was included. Chapter V will provide a discussion of the results of the study in relation to significance, implications, limitations, and suggestions for further research.

CHAPTER V

SUMMARY, LIMITATIONS, IMPLICATIONS AND RECOMMENDATIONS

Introduction

Chapter V presents, first a brief summary of the results of the study based on the data discussed in Chapter IV. Limitations of the study follow and includes those limitations suggested by the data analysis as well as by theory and related research. This chapter concludes with implications and suggestions for further research.

Summary of the Results

The results of the study indicate that, in general, the Head Nurses had high self concepts but tended to view themselves differently on the two instruments that measured leadership styles. If they were high on Structure and Consideration, they tended to view themselves as low on the High Task/High Relationship leadership style quadrant. There was no relationship between the Head Nurses' views of their leadership style and the views of their Nursing Staff for either Structure and Consideration or Task and Relationship Behavior. There were, also, no relationships between the Head Nurse's self perceived leadership styles and the effectiveness ratings of either superiors or subordinates.

For the Nursing Staff, there was similarity in the views of the staff about the leadership style of their respective

Head Nurse, and significant correlations between Structure and Consideration and the respective Task and Relationship Behaviors. The Nursing Staff and the Nursing Supervisors' views of the Head Nurses' effectiveness were similar. The other perceived leadership styles of Head Nurses were correlated significantly with the effectiveness ratings of both superiors and subordinates for Structure, Consideration, Task Behavior and Relationship Behavior. This suggests that if Head Nurses are to be viewed as effective by superiors and subordinates, they should exhibit both Structure and Consideration (or Task and Relationship) behaviors to a high degree.

Limitations of the Study

This section contains a discussion of the factors which limit the results of the investigation. Chapter I provided a brief explanation of limitations which were anticipated in conducting the study. This chapter presents further explanation of these limitations as well as presents the factors involved in the actual implementation of the study which place limitations on the results being interpreted.

The nature of the design of the study, as a field study, places limitations on the interpretation of the results. Kerlinger (1973) describes the field study as ex post facto inquiries "aimed at discovering the relations and interactions

among sociological, psychological, and educational variables in real social structures" (p. 405). There are certain weaknesses in ex post facto research related to control, randomization and interpretation. There is, first of all, an inability to control or manipulate the independent variables in such a study. Secondly, the investigator has no power to randomize, since the field study is done with over all non-random samples. This lack of power limits the investigator's ability to control the independent variables. Finally, there is a risk of improper interpretation of the results. Statements of relationships found in ex post facto research are weaker statements than are those relationships in experimental research desigsn (Kerlinger, 1973).

Any measure of self report of self concept, such as the Tennessee Self Concept Scale, poses limitations because of questions of validity of the instrument of self report. Since the self concept is a phenomenological aspect of self perception, a great deal of validation work must be done to demonstrate that an instrument does produce a valid measure of self concept...a concept which cannot be measured in any completely objective sense. Although the TSCS has been widely used in a large variety of samples, the very fact that it is so widely used requires additional analyses of internal consistency and validity (Crandall, 1973). Fitts, (1965, 1971) has done extensive work in creating the TSCS as a standardized instrument for the measurement of many facets

of the individual's self concept.

The TSCS provides a measure of Total Positive Self Esteem which reflects the information about the parts of the self which the respondent is willing to report. A bias in the self reporting may be suspected as a possibility. In addition, because the TSCS is a self report measure, the issue of inferred self concept versus self report of self concept places a limitation on the interpretation of the results of this study. This has been discussed previously.

The questions of validity and reliability also pertain to the Leader Effectiveness and Adaptability Description--Self and --Other. The instruments have been used most extensively for organization development purposes and therefore, they have not undergone the rigorous study necessary to provide reliability and validity data.

A related limitation applies to the situations which comprise the LEAD instruments themselves. The situations are general descriptions of leadership situations rather than being specific nursing situations requiring leadership decisions. There may have been differences in how the situations were interpreted by the various levels of participants. Four participants mentioned that it was difficult to think of specific instances on their nursing unit that were similar to some of the situations found on the LEAD instrument.

A final limitation is related to the instrument used to measure effectiveness of Head Nurses. The Leadership Effectiveness Rating Form was a measure constructed by the investigator for the study. It was intended to measure several dimensions of nursing leadership effectiveness. The tool was not tested for reliability or validity.

According to Campbell, Dunnette, Lawler and Weick (1970) the commonly used measures of managerial effectiveness have not proven to be satisfactory for a variety of reasons. The common measures have included global measures (such as rankings), objective measures (such as rates of absenteeism) and rating scales and observations of behavior. Some of the reasons for shortcomings of the measures include: a) identification of irrelevant factors, b) incomplete description of job behaviors, c) observer errors, such as "halo" effect, d) limited time perspective for the rating, and e) differences in what is seen and reported by the observers. The authors describe the characteristics of an adequate measure of effectiveness as being job centered and behaviorally based. It should be relevant to what the individual manager does and it should include many or all of the behavioral elements making up the job.

The Leadership Effectiveness Rating Form, as a rating scale has some of the shortcomings listed above, such as

incomplete description of job behaviors for Head Nurses, and being open to different interpretation by raters. At least for one dimension, Delegation of Responsibility, there was an indication that different interpretations had occurred. A high score on this dimension, from the Nursing Supervisors in an Agency, reflected the feeling that the Head Nurse who did a lot of delegation was going it to keep from having to become involved in the work of the nursing unit. For some Head Nurses, then, the high scores were indicative of "laziness", while for others, the high scores were indicative of effective delegation skills.

Implications of the Study

The implications of the study, based on the results of the investigation, will be discussed in this section.

According to the literature (Corrigan & Julian, 1966; Davis, 1969; Kelly, 1974; McBride, Diers & Slavinsky, 1972) nurses tend not to have personality characteristics which could be considered representative of the characteristics of the self-actualized person (Maslow, 1954) or of the person with a positive self concept. Rather than being open to experience, objective of reality, sensitive to own and other's experiences, creative, independent and freely expressive of their own feelings; nurses have been described as submissive, maintaining of subordinate roles, defensive, conforming, constricted in expressing emotions, lacking in creativity, and dependent. The Head Nurses in the sample in this study would therefore

have been expected to have scored below the mean of the normative group on the Tennessee Self Concept Scale. Instead, the Head Nurse sample scored well above the mean and had very high self concepts (94th percentile). This discrepancy between the Head Nurses' self concept scores and the personality characteristics found in the literature might indicate that the Head Nurses' self report was of their "Ideal" self, rather than "Real" self. Perhaps the high self-reported self concept scores reflect repeated, successful experiences which the Head Nurses may have had and which have been integrated into the self concept, so that there is congruence of self and experience (Rogers, 1951, 1961).

With high positive self concepts, the Head Nurses would be expected to have an accurate and efficient view of reality (Maslow, 1954; Rogers, 1961, 1961) and one would expect that their self perceptions of leadership style would be consistent when measured on two different instruments. The Head Nurses' self perceived leadership styles for Structure and Consideration did not agree with their self perceived leadership styles of Task or Relationship Behavior. This suggests that either the Total Positive score on the Tennessee Self Concept Scale is not an accurate measure of self concept or that the instruments measuring leadership style are at fault. The two instruments (LOQ and LEAD-Self) may not be measuring the same leader behavior dimensions. It may be that Structure

and Consideration, as indices of leader behavior, are indicative of process and are, thus, changing dimensions; whereas Task Behavior is indicative of actual and specific tasks to be accomplished. The Head Nurses may have interpreted the two instruments quite differently, then, with the LOQ being interpreted in relation to leadership as a process and the LEAD-Self being interpreted in relation to the specific tasks identified in the situations. Either instrument (LOQ, LEAD-Self) could also have been responded to by the Head Nurse in relation to her view of ideal leader behavior. One instrument might indicate ideal behavior while the other instrument might indicate real behavior.

Personality theories assume that people have a need to behave consistently (Jourard, 1974; Maslow, 1954; Patterson, 1973; Rogers, 1951, 1961). This would lead one to expect that the Head Nurses would describe themselves in the same way on the two instruments that purport to measure similar leader behaviors. The fact that the Head Nurses viewed themselves in opposite directions on the two instruments might suggest that behavior is largely situation specific and that the consistency assumption is in error (Hilgard, Atkins & Atkins, 1975). The differences might also be related to the way the instruments are worded. Certainly, the answers one gives to questions are, in part, a function of the way in which the questions are worded. Because of the limited testing of the LEAD-instruments, the discrepancy

in self perception of leadership style by the Head Nurses might be a function of weakness in the design and construction of the LEAD-Self instrument, itself. A final consideration that may account for the differences in scores by Head Nurses in the two instruments is the issue of social desireability. Head Nurses may have completed the LOQ in such a way as to present themselves in the best possible light. Answers may have been given which reflect what the Head Nurse perceives to be the desired kinds of behavior which she believes to be important for the job (Campbell, et al, 1970, pp. 138-139).

While the high self concept scores and discrepancy of self perceived leadership style by Head Nurses are not consistent with self concept and self perception theories, the findings of this study for Nursing Staff and Nursing Supervisors have implications for future study. The discrepancy between the Head Nurse's view of her leadership style and the view of the Nursing Staff is consistent with literature related to studies of leadership (Distefano & Pryer, 1973; Evan, cited in Georgopoulos, 1975; Likert, 1961; Scott, 1956; Stogdill & Shartle, 1955). However, the results of this study indicate that the perceptions of the Nursing Staff, of the leadership styles of their respective Head Nurses, are consistent between the two instruments which measure similar dimensions.

Perhaps, more importantly, the effectiveness ratings of Head Nurses are correlated positively with the higher Structure and Consideration scores and with the High Task/ High Relationship leadership style. The effectiveness scores of both superiors and subordinates are similar and are not correlated with the self perceived leadership styles of the Head Nurses, but the effectiveness scores are significantly related to the perceptions of leadership style of the Head Nurses as perceived by their followers. This suggests that the way in which the leader perceives his own leader behavior is much less important than the way in which subordinate's view his leadership style. It would be important, therefore, for the Head Nurses to know how their Nursing Staff view their leader behavior, since effectiveness was closely related to a High Task/High Relationship leadership style and significantly and negatively correlated with a Low Task/Low Relationship leadership style. The implication for the Head Nurse to know the dominant leadership style she is perceived as having by her Nursing Staff could indicate whether or not she is perceived as effective by her staff and superiors. This information would not necessarily tell the Head Nurse what should be done, but rather, it would provide her with descriptions of what types of leader behaviors were seen as existing at a particular time.

The findings of the study support certain stated assumptions in behavioral science and organizational behavior

literature. The assumptions that are supported by the findings of this study are that the leader's perceptions of leadership style are of less importance than the perceptions of followers (Hersey & Blanchard, 1972), and that leadership effectiveness depends on the perceptions of the followers and superiors (Barnard, 1948; Hemphill, 1949; Hersey & Blanchard, 1972; Hollander & Julian, 1969).

The findings also provide a beginning, and partial answer to Leininger's (1974) statement that, "...the effects of different leadership styles in relation to leadership effectiveness and retention have yet to be explored in (nursing) research studies" (p. 33). In this study, the leadership styel of High Task/High Relationship was positively and significantly related to the Head Nurse's effectiveness as viewed by staff and superiors, and negatively related to the leadership style of Low Task/Low Relationship. It may be that the High Task/High Relationship leadership style is the most appropriate leadership style for Head Nurses to use with Nursing Staff in acute care hospital settings. Certainly the findings of this study warrant further study in relation to this issue raised by Leininger.

Leadership styles of Head Nurses, as perceived by others, could provide a data base upon which staff development programs could be organized. Since leadership effectiveness is defined as, "the ability of the leader to adapt his or her leadership style to meet the needs of the followers and the

needs of the situation" (Hersey & Blanchard, 1972), and since followers have definite opinions about the adequacy of a leader's performance in a given situation (Hemphill, 1949; Hersey & Blanchard, 1972; Hollander & Julian, 1969), nurses who are in Head Nurse positions should be aided both to identify the needs of their followers and to develop leadership behavior styles appropriate to the needs of followers and situation (Hersey & Blanchard, 1972).

One's self concept is extremely important in determining behavior (Combs & Snygg, 1959; Fitts, 1971, 1972a, 1972b; Wiley, 1974). If one's self concept is comprised of one's perceptions of "reality" (Combs & Snygg, 1959; Hersey & Blanchard, 1974; Maslow, 1954; Rogers, 1951, 1961) with "reality" being what is perceived and with "reality" influencing the behavior, then it would be important for nurses in leadership positions to know about the perceptions of their followers as part of this "reality". It would be equally important for the Head Nurses to know of their own perceptions which contribute to their view of "reality". If the Head Nurses' perceptions could be broadened to include the perceptions of followers, perhaps the nurses would be seen as more effective by superiors and subordinates.

Because the High Task/High Relationship leadership style was so significantly related to effectiveness, as viewed

by followers and superiors, one wonders if the Nursing Staff are not at an average to low average level of maturity (Hersey & Blanchard, 1972). The Head Nurses who have a High Task/ High Relationship, dominant, leadership style may have correctly and appropriately been using a leadership style that is consistent with the needs of their subordinates. Assuming that the LEAD-Other instrument is a valid tool, the results of this relationship (High Task/High Relationship to effectiveness) is probably more chance than planned action, since the effectiveness dimension scores on the LEAD instruments were not high for Head Nurses, and were even lower for Nursing Staff. This demonstrated that neither Head Nurse nor Nursing Staff member was able to accurately diagnose the situations on the LEAD instruments in relation to the Life Cycle Theory of Leadership. This was expected since no information on the theory was given to the sample prior to testing. The implication that Life Cycle Theory of Leadership, by way of inservice education or basic nursing education, would be beneficial to nurses is clearly in need of further exploration.

Based on the findings of this study, that the High Task/High Relationship leadership style correlates positively with effectiveness, further testing of Life Cycle Theory of Leadership is needed. The Life Cycle Theory of Leadership would assume that the Head Nurse who has a wider range of

leadership styles to use, and who by accurate diagnosis of followers needs and situational demands, uses those styles appropriately would tend to be viewed as effective by followers and superiors. Staff development and curricular offerings could easily be developed that would provide for this type of leadership skill.

Another finding was that Nursing Supervisors tended to see Head Nurses as more effective in Communication than did the Nursing Staff. This may be consistent with a bureaucratic view of the organization (Kramer, 1974; Litterer, 1969) in which communication in a bureaucracy is seen as flowing downward. On the one hand, the Nursing Supervisors may view the Head Nurses as effective in relaying administrative message downward to the Nursing Staff, a task which is one of the supervisor's responsibilities. On the other hand, the Nursing Staff's view of the Head Nurse is one of less effectiveness in communicating their ideas and concerns upward to administration. Since communications are an important part of both Task and Relationship Behaviors in leaders, and since the perceptions of followers are more important in determining effectiveness, than the perceptions of superiors, the dimension of communication is worthy of further study.

The major hypotheses of this study were that the higher the self concept of the leader, the closer would be the congruency between self and other perceived leadership style and effectiveness. While the thesis was born out in

one agency, it was not supported in the second agency, and one must question why this occurred. The Head Nurses' self concept scores on the Tennessee Self Concept Scale were well above the mean for the normative group. The Self Criticism scores, which could indicate inflation of the Total Positive Scores if low, were very near the mean for the normative group, thus indicating that the Total Positive Scores were accurate self report scores for the Head Nurses.

Since the scores of self report for Head Nurses were practically identical in both agencies, there must be other factors influencing the congruency of perceptions. Age and length of time in position may be two such factors. Head Nurses and Registered Nurses and Aides in Agency A, on the average, were slightly older than their respective counterparts in Agency B. The Licensed Practical Nurses were almost identical in age in both agencies. The Nursing Supervisors, while one year older on the average in Agency B, had five years more of experience in Agency A than in Agency B. The nursing unit personnel in Agency B have been together for a shorter period of time, with the Head Nurses, Registered Nurses, and Aides younger in age than their respective groups in Agency A. Since the factor of age is so close between groups, it may be that the critical value involved in the differences is either length of work experience or length of time together as a group. It may be

a combination of both length of experience and group cohesiveness.

The length of experience in the position for Head Nurses in Agency A was twice that of the Head Nurses in Agency B. The same was true for the non-professional staff. This suggests that length of experience may be more important in determining congruence of leader behavior perceptions than the other dimensions. The longer a group of people work together, the more accurate they will become in their perceptions of each other's abilities and behaviors--whether they be leaders or followers. The factors of age and length of time in the position, and their relationship to congruency between self and other perceived leadership style and effectiveness and the degree of self concept demand further study.

Another implication of the study relates to the direction of difference between the Head Nurses' views of their leadership style and views of their Nursing Staff. Perhaps the direction of the discrepancy between self and other perceived leadership styles and effectiveness is equally as important as the size of the discrepancy, itself. Certainly, the larger the size of the discrepancy, the less congruent the scores, but perhaps the direction of the discrepancy is important as well. One question raised is whether or not it should be expected that individuals scoring high on self

concept would also score higher on the leadership style behaviors.' This tended to be the case in this study, with the Head Nurses perceiving themselves as higher on Structure and Task Behaviors and Consideration and Relationship Behaviors than did their Nursing Staff. Another question is, does a higher positive self concept include behaviors that would be considered High Task/High Relationship in nature? Neither of these questions were dealt with by the study reported here.

A final area for future study is concerned with nursing education programs, and the inclusion or exclusion of content and experiences that deal with leadership theory and skills. That nurses will continue to function in leadership positions is clear from the current practice settings. That nurses will assume different types of leadership positions is clearly evident from the direction in which health care practice settings are moving, i.e. ambulatory care and Health Maintenance Organizations. Professional nursing programs need to provide theoretical and experiential learnings in Organizational Theory, Organizational Behavior and Organization Development in order for graduates to function effectively and realistically in a variety of settings (Kramer, 1973).

This section has presented some implications resulting from this study. The next section will suggest areas for further research.

Suggestions for Further Research

Based on the implications resulting from the study, several suggestions can be made for further research. The suggestions are related to either replication of this study, or to further documentation and study of the findings resulting from this study.

An obvious area for further documentation is the area of measurement of self concept of Head Nurses. To determine if the nurses do tend to have higher and more homogeneous scores of self report, two instruments that measure self report of self concept could be administered to a group of randomly selected Head Nurses. This could provide a measure of validity for the degree of self concept findings. Concurrent with the measures of self report, observers who have been trained to observe the Head Nurses' behaviors could determine the inferred self concept (Combs & Snygg, 1959; Combs & Soper, 1957, 1963; Combs et al, 1963). Two additional measures of self concept could also be obtained--the "Ideal" self and the self concept as perceived by peers of the Head Nurse. As Crandall (1973) indicates, correlations are needed between the self concept (self report or inferred self concept) and peer reports of self concept. Correlational studies, from such a data base, could be computed between the various measures of self. Figure 10

shows the correlational studies that could be computed from these measures.

Measures of Self Concept	Measures of Self Concept				
	Self Report 1	Self Report 2	Inferred Self	Ideal Self	Peer Report
Self Report 1		X	X	X	X
Self Report 2	X		X	X	X
Inferred Self	X	X		X	X
Ideal Self	X	X	X		X
Peer Report	X	X	X	X	

Figure 10. Correlational Studies of Various Measures of Self Concept - Future Research

Such a study might well identify those Head Nurses whose self concepts are more positive than others.

This study could be replicated in a different type of organization, to see if the findings are similar. The study could also be replicated in other acute care, general hospital settings, as well as in other health care systems to see if the findings hold. A careful design that includes the randomization of the sample might provide a clearer picture of the relationship between self concept and the congruency of leadership styles as viewed by leader and subordinates.

Another area suggested for further research is concerned with the lack of reliability and validity studies for the LEAD instruments. Such studies would lend support to the use of the instruments in future studies of leadership styles and effectiveness and relationships to a variety of factors in the situation which may be influencing the leader and/or the followers, such as, organizational structure, measures of job satisfaction, hygiene or motivator factors, etc.

A related area, requiring study, is a need for an objective, reliable and valid instrument for identifying the maturity level of both leaders and followers. The components of maturity, for followers, as defined by Hersey and Blanchard (1972), are achievement motivation, willingness and ability to assume responsibility, and task relevant education and experience. The components are, perhaps, too general to be able to accurately identify the followers' maturity levels. And what are the implications when the leader is below average in maturity? Given the characteristics of nurses, previously described, and the implications that nurses are neither prepared for, nor do they seek out leadership positions (McBride, et al, 1972) the inconsistency in the findings of the study might well relate to the level of maturity--immaturity of the leaders studied. If, as Diers and McBride (1972) indicate, nurses in leadership positions are there against their will and

desire, and are ill prepared to be functioning in the leadership positions, then one must question whether the Head Nurses have two of the characteristics of maturity (Hersey & Blanchard, 1972). The two characteristics open to question for the Head Nurses would be first, their willingness and ability to assume responsibility and secondly, their degree of task relevant education and experience. Although Head Nurses are designated as leaders in the organizational structure, they may be lower in maturity than their followers.

An experimental design for a future study is suggested by this study. The same hypotheses could be tested. Head Nurses could be randomly selected and placed into three groups. The Control Group, and two Experimental Groups. Each group would be pre-tested with the Tennessee Self Concept Scale, the Leader Opinion Questionnaire, the LEAD-Self, and an instrument for self evaluation of leadership style and effectiveness. Leadership style and effectiveness measures and "Peer" report of self concept could also be obtained from Nursing Staff for Head Nurses in each group. Experimental Group A would be involved in an ongiong sensitivity group as a staff development program. This program would be directed at increasing the positive direction of the self concept. Experimental Group B would undergo a staff development program that included both the

sensitivity group model to make the self concept more positive, and classes on Life Cycle Theory of Leadership, group skills and diagnostic skills. Following completion of the staff development programs, measures of self concept (self report, Ideal self, Inferred self and Peer Report), measures of self and other perceived leadership style and measures of leadership effectiveness would be obtained for each of the experimental groups and for the control group. Such a design would eliminate some of the weaknesses of the present study, namely lack of randomization, lack of control of variables and the risk of improper interpretation (Kerlinger, 1973).

As reported in this study, the perceptions of subordinates of the Head Nurse are consistent on both leadership instruments. It would seem important for the Head Nurse to have access to those perceptions. Another type of staff development program could be aimed at providing Head Nurses, Nursing Staff, and Nursing Supervisors with skills in using concepts from Organization Development. Such skills as organizational climate scale interpretation and other diagnostic skills to aid in generating data about the "health" of the organization would be included. A staff development program like this, to provide the Nursing Service personnel with the ability to become a self renewing and self correcting organization by providing means of maximizing the

potential of the personnel, could be tested for its effectiveness. If the personnel are growing and changing in positive ways, then it would seem evident that the recipients of their services--the patients--would be more satisfied with their care while hospitalized. Patient satisfaction could be measured, as well, by questionnaire or skilled interview.

Conclusion

The major findings of this study can be summarized as follows:

First, the three general hypotheses presented in Chapters 1 and 2 tended to be supported by this study. The greater the extent of positive self concept, the more congruent were the leader's self perception of leadership style and effectiveness with the perception of others of the leader's leadership style and effectiveness. The more congruent the leader's self perception was with the perception of others, the higher the effectiveness of the Head Nurse as perceived by follwers. The greater the extent of the Head Nurse's positive self concept, the greater was the perceived effectiveness of the Head Nurse by her Nursing Staff.

Self concept, congruency of self perception of leadership style with other-perception of leadership style and leader effectiveness are positively related to each other.

Secondly, the findings indicate that the High Task/ High Relationship leadership style is the most effective

style for the Head Nurses to be using with their Nursing Staff. Whereas behaviors involving high degrees of Structure (Task) and Consideration (Relationship) behaviors are most appropriate, behaviors that are low in these dimensions rate a lower effectiveness score by the Nursing Staff.

Thirdly, the findings of the study demonstrated that there is a relationship between the High Task/High Relationship leadership quadrant on the LEAD-Other and the Structure and Consideration dimensions of the LBDQ. The Low Task/ Low Relationship leadership quadrant also showed strong relationships with both the Structure and Consideration dimensions. This is one of the earliest demonstrations that the LEAD-Other and the LBDQ are measuring similar types of leader behaviors.

Finally, the Head Nurses had high self concept scores in this study. This is a finding that is not consistent with other findings and generalizations in the literature in nursing.

Nurses will continue to be designated as leaders in health care systems. Further research in the area of leadership styles and effectiveness is needed. Such studies could be directed at providing a base for Inservice Education programs that give the nursing leaders the task relevant education needed for them to function effectively in leadership positions. Such studies might also provide data

on women in leadership positions, since the nursing profession is predominantly a female occupation. The need to guarantee or to assure quality care for patients demands that there be effective leadership by nurses in the health care systems.

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APPENDIX

APPENDIX A

DIRECTIONS: Fill in your name and other information on the separate answer sheet.

The statements in this inventory are to help you describe yourself as you see yourself. Please answer them as if you were describing yourself to yourself. Reach each item carefully; then select one of the five responses below and fill in the answer space on the separate answer sheet.

Don't skip any items. Answer each one. Use a soft lead pencil. Pens won't work. If you change an answer, you must erase the old answer completely and enter the new one.

RESPONSES	Completely False	Mostly False	Partly False and Partly True	Mostly True	Completely True
	C F 1	M F 2	PF-PT 3	M T 4	C T 5

TENNESSEE SELF CONCEPT SCALE

1.	I have a healthy body.....	1
2.	I am an attractive person.....	2
3.	I consider myself a sloppy person.....	3
4.	I am a decent sort of person.....	4
5.	I am an honest person.....	5
6.	I am a bad person.....	6
7.	I am a cheerful person.....	7
8.	I am a calm and easy going person.....	8
9.	I am a nobody.....	9
10.	I have a family that would always help me in any kind of trouble.....	10
11.	I am a member of a happy family.....	11
12.	My friends have no confidence in me.....	12
13.	I am a friendly person.....	13
14.	I am popular with men.....	14
15.	I am not interested in what other people do.....	15
16.	I do not always tell the truth.....	16
17.	I get angry sometimes.....	17
18.	I like to look nice and neat all the time.....	18
19.	I am full of aches and pains.....	19
20.	I am a sick person.....	20

21. I am a religious person..... 21
22. I am a moral failure..... 22
23. I am a morally weak person..... 23
24. I have a lot of self-control..... 24
25. I am a hateful person..... 25
26. I am losing my mind..... 26
27. I am an important person to my friends and family.... 27
28. I am not loved by my family..... 28
29. I feel that my family doesn't trust me..... 29
30. I am popular with women..... 30
31. I am mad at the whole world..... 31
32. I am hard to be friendly with..... 32
33. Once in a while I think of things too bad to talk about..... 33
34. Sometimes when I am not feeling well, I am cross..... 34
35. I am neither too fat nor too thin..... 35
36. I like my looks just the way they are..... 36
37. I would like to change some parts of my body..... 37
38. I am satisfied with my moral behavior..... 38
39. I am satisfied with my relationship to God..... 39
40. I ought to go to church more..... 40
41. I am satisfied to be just what I am..... 41
42. I am just as nice as I should be..... 42
43. I despise myself..... 43
44. I am satisfied with my family relationships..... 44
45. I understand my family as well as I should..... 45
46. I should trust my family more..... 46
47. I am as sociable as I want to be..... 47
48. I try to please others, but I don't overdo it..... 48
49. I am no good at all from a social standpoint..... 49
50. I do not like everyone I know..... 50
51. Once in a while, I laugh at a dirty joke..... 51
52. I am neither too tall nor too short..... 52
53. I don't feel as well as I should..... 53
54. I should have more sex appeal..... 54
55. I am as religious as I want to be..... 55
56. I wish I could be more trustworthy..... 56
57. I shouldn't tell so many lies..... 57
58. I am as smart as I want to be..... 58
59. I am not the person I would like to be..... 59
60. I wish I didn't give up as easily as I do..... 60
61. I treat my parents as well as I should (Use past tense if parents are not living)..... 61
62. I am too sensitive to things my family say..... 62
63. I should love my family more..... 63
64. I am satisfied with the way I treat other people..... 64
65. I should be more polite to others..... 65
66. I ought to get along better with other people..... 66
67. I gossip a little at times..... 67
68. At times I feel like swearing..... 68

69. I take good care of myself physically..... 69
70. I try to be careful about my appearance..... 70
71. I often act like I am "all thumbs"..... 71
72. I am true to my religion in my everyday life..... 72
73. I try to change when I know I'm doing things that are wrong..... 73
74. I sometimes do very bad things..... 74
75. I can always take care of myself in any situation.... 75
76. I take the blame for things without getting mad..... 76
77. I do things without thinking about them first..... 77
78. I try to play fair with my friends and family..... 78
79. I take a real interest in my family..... 79
80. I give in to my parents (Use past tense if parents are not living)..... 80
81. I try to understand the other fellow's point of view. 81
82. I get along well with other people..... 82
83. I do not forgive others easily..... 83
84. I would rather win than lose in a game..... 84
85. I feel good most of the time..... 85
86. I do poorly in sports and games..... 86
87. I am a poor sleeper..... 87
88. I do what is right most of the time..... 88
89. I sometimes use unfair means to get ahead..... 89
90. I have trouble doing the things that are right..... 90
91. I solve my problems quite easily..... 91
92. I change my mind a lot..... 92
93. I try to run away from my problems..... 93
94. I do my share of work at home..... 94
95. I quarrel with my family..... 95
96. I do not act like my family thinks I should..... 96
97. I see good points in all the people I meet..... 97
98. I do not feel at ease with other people..... 98
99. I find it hard to talk with strangers..... 99
100. Once in a while I put off until tomorrow what I ought to do today..... 100

APPENDIX B

LEADER OPINION QUESTIONNAIRE
Adapted from Form
Developed by Staff Members of the
Ohio State Leadership Studies

Your Name _____ Code # _____

Nursing Unit Involved _____ Nursing Unit _____

On the following pages is a list of items that may be used to describe your behavior as Head Nurse. Each item describes a specific kind of behavior, but does not ask you to judge whether the behavior is desirable or undesirable. This is not a test of ability. It simply asks you to describe, as accurately as you can, your behavior as a Head Nurse.

Note: The term, "group" as employed in the following items, refers to a department, division or other unit of organization which you supervise. The term, "members" refers to all the people in the unit of organization which you supervise.

DIRECTIONS:

a. READ each item carefully.

b. THINK about how frequently you, as leader, engage in the behavior described by the item.

c. DECIDE whether you always, often, occasionally, seldom or never act as described by the item.

d. DRAW A CIRCLE around one of the five letters following the item to show the answer you have selected.

A = Always
B = Often
C = Occasionally
D = Seldom
E = Never

1.	I do personal favors for group members.	A	B	C	D	E
2.	I make my attitudes clear to the group.	A	B	C	D	E
3.	I do little things to make it pleasant to be a member of the group.	A	B	C	D	E
4.	I try out my new ideas with the group.	A	B	C	D	E
5.	I act as the real leader of the group.	A	B	C	D	E
6.	I am easy to understand.	A	B	C	D	E
7.	I rule with an iron hand.	A	B	C	D	E
8.	I find time to listen to group members.	A	B	C	D	E
9.	I criticize poor work.	A	B	C	D	E
10.	I give advance notice of changes.	A	B	C	D	E
11.	I speak in a manner not to be questioned.	A	B	C	D	E
12.	I keep to myself.	A	B	C	D	E
13.	I look out for the person welfare of individual group members.	A	B	C	D	E

		Always	Often	Occasionally	Seldom	Never
14.	I assign group members to particular tasks.	A	B	C	D	E
15.	I am the spokesman of the group.	A	B	C	D	E
16.	I schedule the work to be done.	A	B	C	D	E
17.	I maintain definite standards of performance.	A	B	C	D	E
18.	I refuse to explain my actions.	A	B	C	D	E
19.	I keep the group informed.	A	B	C	D	E
20.	I act without consulting the group.	A	B	C	D	E
21.	I back up the members in their actions.	A	B	C	D	E
22.	I emphasize the meeting of deadlines.	A	B	C	D	E
23.	I treat all group members as my equal.	A	B	C	D	E
24.	I encourage the use of uniform procedures.	A	B	C	D	E
25.	I get what I ask for from my superiors.	A	B	C	D	E
26.	I am willing to make changes.	A	B	C	D	E
27.	I make sure that my part in the organization is understood by group members.	A	B	C	D	E
28.	I am friendly and approachable.	A	B	C	D	E
29.	I ask that group members follow standard rules and regulations.	A	B	C	D	E
30.	I fail to take necessary action.	A	B	C	D	E
31.	I make group members feel at ease when talking with them.	A	B	C	D	E

		Always	Often	Occasionally	Seldom	Never
32.	I let group members know what is expected of them.	A	B	C	D	E
33.	I speak as the representative of the group.	A	B	C	D	E
34.	I put suggestions made by the group into operation.	A	B	C	D	E
35.	I see to it that group members are working up to capacity.	A	B	C	D	E
36.	I let other people take away my leadership in the group.	A	B	C	D	E
37.	I get my superiors to act for the welfare of the group members.	A	B	C	D	E
38.	I get group approval in important matters before going ahead.	A	B	C	D	E
39.	I see to it that work of group members is coordinated.	A	B	C	D	E
40.	I keep the group working together as a team.	A	B	C	D	E

APPENDIX C

Your Name _____ Code # _____

Nursing Unit Which You Lead _____ Nursing Unit _____

L E A D S E L F

Self Perception

Directions:

Assume you are involved in each of the following twelve situations. Each situations has four alternative actions you might initiate. READ each item carefully. THINK about what you would do in each circumstance. Then CIRCLE the letter of the alternative action choice which you think would most closely describe your behavior in the situation presented. Circle only one choice.

Leader
Effectiveness and
Adaptability
Description
(formerly Leader Adaptability and Style
Inventory)

Published by

Center for Leadership Studies
Ohio University
Athens, Ohio 45701

Leader Effectiveness and Adaptability Description - Self

SITUATION	ALTERNATIVE ACTIONS
1. Your subordinates are not responding lately to your friendly conversation and obvious concern for their welfare. Their performance is in a tailspin.	A. Emphasize the use of uniform procedures and the necessity for task accomplishment. B. Make yourself available for discussion but don't push. C. Talk with subordinates and then set goals. D. Intentionally do not intervene.
SITUATION	ALTERNATIVE ACTIONS
2. The observable performance of your group is increasing. You have been making sure that all members were aware of their roles and standards.	A. Engage in friendly interaction, but continue to make sure that all members are aware of their roles and standards. B. Take no definite action. C. Do what you can to make the group feel important and involved. D. Emphasize the importance of deadlines and tasks.
SITUATION	ALTERNATIVE ACTIONS
3. Members of your group are unable to solve a problem themselves. You have normally left them alone. Group performance and interpersonal relations have been good.	A. Involve the group and together engage in problem-solving. B. Let the group work it out. C. Act quickly and firmly to correct and redirect. D. Encourage group to work on problem and be available for discussion.

SITUATION	ALTERNATIVE ACTIONS
4. You are consideraing a major change. Your subordinates have a fine record of accomplishment. They respect the need for change.	A. Allow group involvement in developing the change, but don't push. B. Announce changes and then implement with close supervision. C. Allow group to formulate its own direction. D. Incorporate group recommendations, but you direct the change.
SITUATION	ALTERNATIVE ACTIONS
5. The performance of your group has been dropping during the last few months. Members have been unconcerned with meeting objectives. Redefining roles has helped in the past. They have continually needed reminding to have their tasks done on time.	A. Allow group to formulate its own direction. B. Incorporate group recommendations, but see that objectives are met. C. Redefine goals and supervise carefully. D. Allow group involvement in setting goals, but don't push.
SITUATION	ALTERNATIVE ACTIONS
6. You stepped into an efficiently run situation. The previous administrator ran a tight ship. You want to maintain a productive situation, but would like to begin humanizing the environment.	A. Do what you can to make group feel important and involved. B. Emphasize the importance of deadlines and tasks. C. Intentionally do not intervene. D. Get group involved in decision-making, but see that objectives are met.

SITUATION	ALTERNATIVE ACTIONS
7. You are considering major changes in your organizational structure. Members of the group have made suggestions about needed change. The group has demonstrated flexibility in its day-to-day operations.	A. Define the change and supervise carefully. B. Acquire group's approval on the change and allow members to organize the implementation. C. Be willing to make changes as recommended, but maintain control of implementation. D. Avoid confrontation; leave things alone.

SITUATION	ALTERNATIVE ACTIONS
8. Group performance and interpersonal relations are good. You feel somewhat unsure about your lack of direction of the group.	A. Leave the group alone. B. Discuss the situation with the group and then initiate necessary changes. C. Take steps to direct subordinates toward working in a well-defined manner. D. Be careful of hurting boss-subordinate relations by being too directive.

SITUATION	ALTERNATIVE ACTIONS
9. Your superior has appointed you to head a task force that is far overdue in making requested recommendations for change. The group is not clear on its goals. Attendance at sessions has been poor. Their meetings have turned into social gatherings. Potentially they have the talent necessary to help.	A. Let the group work it out. B. Incorporate group recommendations, but see that objectives are met. C. Redefine goals and supervise carefully. D. Allow group involvement in setting goals, but don't push.

SITUATION	ALTERNATIVE ACTIONS
10. Your subordinates usually able to take responsibility, are not responding to your recent redefining of standards.	A. Allow group involvement in redefining standards, but don't push. B. Redefine standards and supervise carefully. C. Avoid confrontation by not applying pressure. D. Incorporate group recommendations, but see that new standards are met.

SITUATION	ALTERNATIVE ACTIONS
11. You have been promoted to a new position. The previous supervisor was uninvolved in the affairs of the group. The group has adequately handled its tasks and direction. Group inter-relations are good.	A. Take steps to direct subordinates toward working in a well-defined manner. B. Involve subordinates in decision-making and reinforce good contributions. C. Discuss past performance with group and then you examine the need for new practice. D. Continue to leave group alone.

SITUATION	ALTERNATIVE ACTIONS
12. Recent information indicates some internal difficulties among subordinates. The group has a remarkable record of accomplishment. Members have effectively maintained long range goals. They have worked in harmony for the past year. All are well qualified for the task.	A. Try out your solution with subordinates and examine the need for new practice. B. Allow group members to work it out themselves. C. Act quickly and firmly to correct and redirect. D. Make yourself available for discussion, but be careful of hurting boss-subordinate relations

APPENDIX D

LEADER BEHAVIOR DESCRIPTION QUESTIONNAIRE
Adapted from form
Developed by staff members of
The Ohio State Leadership Studies

Name of Head Nurse Described ___ Code # _____

Name of Group Which She Leads ___ Nursing Unit _____

Your Name _____ Code # _____

On the following pages is a list of items that may be used to describe the behavior of your Head Nurse. Each item describes a specific kind of behavior, but does not ask you to judge whether the behavior is desirable or undesirable. This is not a test of ability. It simply asks you to describe, as accurately as you can, the behavior of your Head Nurse.

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

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

Published by
Center for Business and Economic Research
Division of Research
College of Administrative Sciences
The Ohio State University
Columbus, Ohio 43210

DIRECTIONS:

a. READ each item carefully.

b. THINK about how frequently your Head Nurse engages in the behavior described by the item.

c. DECIDE whether she always, often, occasionally, seldom or never acts as described by the item.

d. DRAW A CIRCLE around one of the five letters following the item to show the answer you have selected.

A = Always
B = Often
C = Occasionally
D = Seldom
E = Never

1.	She does personal favors for group members.	A B C D E
2.	She makes her attitudes clear to the group.	A B C D E
3.	She does little things to make it pleasant to be a member of the group.	A B C D E
4.	She tries out her new ideas with the group.	A B C D E
5.	She acts as the real leader of the group.	A B C D E
6.	She is easy to understand.	A B C D E
7.	She rules with an iron hand.	A B C D E
8.	She finds time to listen to group members.	A B C D E
9.	She criticizes poor work.	A B C D E
10.	She gives advance notice of changes.	A B C D E
11.	She speaks in a manner not to be questioned.	A B C D E

		Always	Often	Occasionally	Seldom	Never
12.	She keeps to her self.	A	B	C	D	E
13.	She looks out for the personal welfare of individual group members.	A	B	C	D	E
14.	She assigns group members to particular tasks.	A	B	C	D	E
15.	She is the spokesman of the group.	A	B	C	D	E
16.	She schedules the work to be done.	A	B	C	D	E
17.	She maintains definite standards of performance.	A	B	C	D	E
18.	She refused to explain her actions.	A	B	C	D	E
19.	She keeps the group informed.	A	B	C	D	E
20.	She acts without consulting the group.	A	B	C	D	E
21.	She backs up the members in their actions.	A	B	C	D	E
22.	She emphasizes the meeting of deadlines.	A	B	C	D	E
23.	She treats all group members as her equals.	A	B	C	D	E
24.	She encourages the use of uniform procedures.	A	B	C	D	E
25.	She gets what she asks for from her superiors.	A	B	C	D	E
26.	She is willing to make changes.	A	B	C	D	E
27.	She makes sure that her part in the organization is understodd by group members.	A	B	C	D	E

		Always	Often	Occasionally	Seldom	Never
28.	She is friendly and approachable.	A	B	C	D	E
29.	She asks that group members follow standard rules and regulations.	A	B	C	D	E
30.	She fails to take necessary action.	A	B	C	D	E
31.	She makes group members feel at ease when talking with them.	A	B	C	D	E
32.	She lets group members know what is expected of them.	A	B	C	D	E
33.	She speaks as the representative of the group.	A	B	C	D	E
34.	She puts suggestions made by the group into operation.	A	B	C	D	E
35.	She sees to it that group members are working up to capacity.	A	B	C	D	E
36.	She lets other people take away her leadership in the group.	A	B	C	D	E
37.	She gets her superiors to act for the welfare of the group members.	A	B	C	D	E
38.	She gets group approval in important matters before going ahead.	A	B	C	D	E
39.	She sees to it that the work of group members is coordinated.	A	B	C	D	E
40.	She keeps the group working together as a team.	A	B	C	D	E

APPENDIX E

Name of Head Nurse Described _____ Code # _____

Nursing Unit Which She Leads _____ Nursing Unit _____

Your Name _____ Code # _____

L E A D O T H E R

Other's Perception

Directions:

Assume your Head Nurse is involved in each of the following twelve situations. Each situation has four alternative actions this leader might initiate. READ each item carefully. THINK about what this person would do in each circumstance. Then CIRCLE the letter of the alternative action choice which you think would most closely describe the behavior of this leader in the situation presented. Circle only one choice.

Leader
Effectiveness and
Adaptability
Description
(formerly Leader Adaptability and Style
Inventory

Published by

Center for Leadership Studies
Ohio University
Athens, Ohio 45701

Leader Effectiveness and Adaptability Description - Other

SITUATION	ALTERNATIVE ACTIONS
1. Subordinates are not responding lately to the leader's friendly conversation and obvious concern for their welfare. Their performance is in a tailspin.	The leader would: A. emphasize the use of uniform procedures and the necessity for task accomplishment. B. be available for discussion but would not push. C. talk with subordinates and then set goals. D. intentionally not intervene.
SITUATION	ALTERNATIVE ACTIONS
2. The observable performance of this leader's group is increasing. The leader has been making sure that all members were aware of their roles and standards.	The leader would: A. engage in friendly interaction, but continue to make sure that all members are aware of their role and standards. B. take no definite action. C. do what could be done to make the group feel important and involved. D. emphasize the importance of deadlines and tasks.
SITUATION	ALTERNATIVE ACTIONS
3. The leader's group is unable to solve a problem. The leader has normally left the group alone. Group performance and interpersonal relations have been good.	The leader would: A. involve the group and together engage in problem-solving. B. let the group work it out. C. act quickly and firmly to correct and redirect. D. encourage group to work on problem and be available for discussion.

SITUATION	ALTERNATIVE ACTIONS
4. The leader is considering a major change. The leader's subordinates have a fine record of accomplishment. They respect the need for change.	The leader would: A. allow group involvement in developing the change but would not push. B. announce changes and then implement with close supervision. C. allow group to formulate its own direction. D. incorporate group recommendations but direct the change.
SITUATION	ALTERNATIVE ACTIONS
5. The performance of this leader's group has been dropping during the last few months. Members have been unconcerned with meeting objectives. Redefining roles has helped in the past. They have continually needed reminding to have their tasks done on time.	The leader would: A. allow group to formulate its own direction. B. incorporate group recommendations, but see that objectives are met. C. redefine goals and supervise carefully. D. allow group involvement in setting goals, but would not push.
SITUATION	ALTERNATIVE ACTIONS
6. The leader stepped into an efficiently run situation. The previous administrator ran a tight ship. The leader wants to maintain a productive situation, but would like to begin humanizing the environment.	The leader would: A. do what could be done to make group feel important and involved. B. emphasize the importance of deadlines and tasks. C. intentionally not intervene. D. get group involved in decision-making, but see that objectives are met.

SITUATION	ALTERNATIVE ACTIONS
7. This leader is considering making major changes in organizational structure. Members of the group have made suggestions about needed change. The group has demonstrated flexibility in day-to-day operations.	The leader would: A. define the change and supervise carefully. B. acquire group's approval on the change and allow members to organize its implementation. C. be willing to make changes as recommended, but maintain control of implementation. D. avoid confrontation, leave things alone.

SITUATION	ALTERNATIVE ACTIONS
8. Group performance and interpersonal relations are good. This leader feels somewhat unsure about the lack of direction given to the group.	The leader would: A. leave the group alone. B. discuss the situation with the group and then initiate necessary changes. C. take steps to direct subordinates toward working in a well-defined manner. D. be careful of hurting boss-subordinate relations by being too directive.

SITUATION	ALTERNATIVE ACTIONS
9. This leader has been appointed by a superior to head a task force that is far overdue in making requested recommendations for change. The group is not clear on its goals. Attendance at sessions has been poor. Their meetings have turned into social gatherings. Potentially they have the talent necessary to help.	The leader would: A. let the group work it out. B. incorporate group recommendations, but see that objectives are met. C. redefine goals and supervise carefully. D. allow group involvement in setting goals, but would not push.

SITUATION	ALTERNATIVE ACTIONS
10. Subordinates, usually able to take responsibility, are not responding to the leader's recent redefining of standards.	The leader would: A. allow group involvement in redefining standars, but would not push. B. redefine standards and supervise carefully. C. avoid confrontation by not applying pressure. D. incorporate group recommendations, but see that new standards are met.

SITUATION	ALTERNATIVE ACTIONS
11. This leader has been promoted to a new position. The previous manager was uninvolved in the affairs of the group. The group has adequately handled its tasks and direction. Group interrelations are good.	The leader would: A. take steps to direct subordinates toward working in a well-defined manner. B. involve subordinates in decision-making and reinforced good contributions. C. discuss past performance with group and then examine the need for new practice. D. continue to leave the group alone.

SITUATION	ALTERNATIVE ACTIONS
12. Recent information indicates some internal difficulties among subordinates. The group has a remarkable record of accomplishment. Members have effectively maintained long range goals. They have worked in harmony for the past year. All are well qualified for the task.	The leader would: A. try out solution with subordinates and examine the need for new practice. B. allow group members to work it out themselves. C. act quickly and firmly to correct and redirect. D. be available for discussion, but be careful of hurting boss-subordinate relations.

APPENDIX F

LEADERSHIP EFFECTIVENESS RATING FORM

Head Nurse Being Rated: Code #

Nursing Unit on Which She Leads: Nursing Unit

Your Name: Code #

This form is intended to obtain a rating of leadership effectiveness for this Head Nurse, as you perceive it. This is not a test. There are no "right" or "wrong" answers. The investigator is simply interested in your judgments and opinions. Please do not omit any items and please mark each item only once.

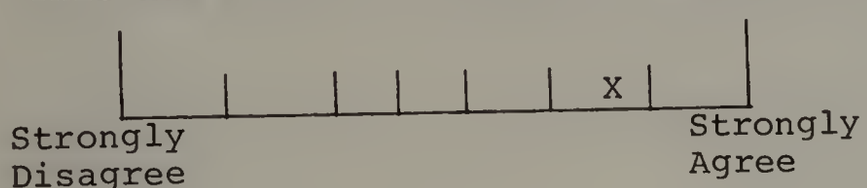
Directions:

READ each of the six items carefully. The range of each item is indicated by the descriptive terms on the left and right sides of the scale. MARK an X in one of the spaces on the scale to indicate your rating of the Head Nurse on that particular item.

PLEASE NOTE: Put the X in the space between the shorter vertical lines and not on the vertical line. Please see the following example.

EXAMPLE

A. This has been an interesting experience.

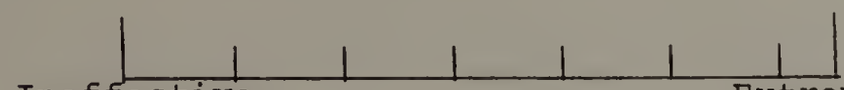


LEADERSHIP EFFECTIVENESS RATING FORM

1. All in all, how effectively do you think this person is performing the job?

Ineffective — Extremely Effective

2. How effectively do you think this person is in providing help with planning nursing care?



Ineffective — Extremely Effective

3. How much supervision do you think this person provides?

Inadequate - too little or too much — Sufficient - provided when needed

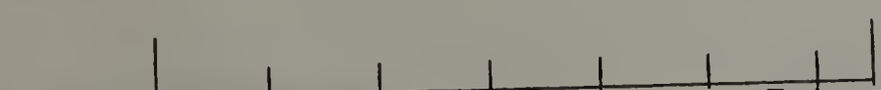
4. How would you describe the channels of communication of this nursing unit?

Closed and primarily one way, downward — Open, downward and upward

5. How much do you think this person delegates to the nursing staff?

Almost None — A great deal is delegated

6. All in all, how satisfied are you with your work?



Very Dissatisfied — Extremely Satisfied

APPENDIX G

PERSONAL DATA SHEET

PERMISSION FORM

Name: _____

Telephone: _____

Address: _____

Age: _____

Sex: _____

Position in Hospital: _____

Length of time in this Position: _____

Unit Assigned: _____

If Registered Nurse or Licensed Practical Nurse, please complete the following three items:

Year of Graduation from Nursing School: _____

Type of Nursing Education Background: _____

Are you a Team Leader? _____

If Nursing Supervisor, or equivalent, please complete the following item:

Nursing Units Supervised: _____

_____

To Be Completed by All

I agree to be involved in a research project that is to be tested statistically. Permission is granted to publish the results of this study. I understand that no one will be identified by name, nor will the nursing unit or agency be identified by name.

Date: _____ Signature: _____

APPENDIX H

LEADER EFFECTIVENESS AND ADAPTABILITY DESCRIPTION - (SELF AND OTHER)

Directions for Scoring

Circle the letter that you have chosen for each situation on the same line to the right, under Column I (STYLE RANGE) and also Column II (STYLE ADAPTABILITY). After you have circled alternative actions, total the number of circles for each sub-column under Column I (STYLE RANGE) and Column II (STYLE ADAPTABILITY) and enter totals in the spaces provided below.

Processing Data from Column I (Style Range)

Sub-column totals from Column I (Style Range) can be located on the basic styles, (the middle portion) of the Tri-Dimensional Leader Effectiveness Model to the right. The column numbers correspond to the quadrant numbers of the leadership model as follows:

Sub-Column (1) - alternative action choices describe (Quadrant 1), High Task/Low Relationship Behavior.
Sub-Column (2) - alternative action choices describe (Quadrant 2), High Task/High Relationship Behavior.
Sub-Column (3) - alternative action choices describe (Quadrant 3), High Relationships/Low Task Behavior.
Sub-Column (4) - alternative action choices describe (Quadrant 4), Low Task/Low Relationship Behavior.

Enter the totals associated with each of the four basic leadership styles in the boxes provided on the leadership model to the right.

Processing Data from Column II (Style Adaptability)

Multiply the totals entered in sub-columns (a), (b), (c), and (d) to the left by the positive and negative factors in the same sub-columns. Enter the product in the space provided directly below. (Be sure to include pluses and minuses.)

Then Add all four figures and record the sum in the box designated TOTAL.

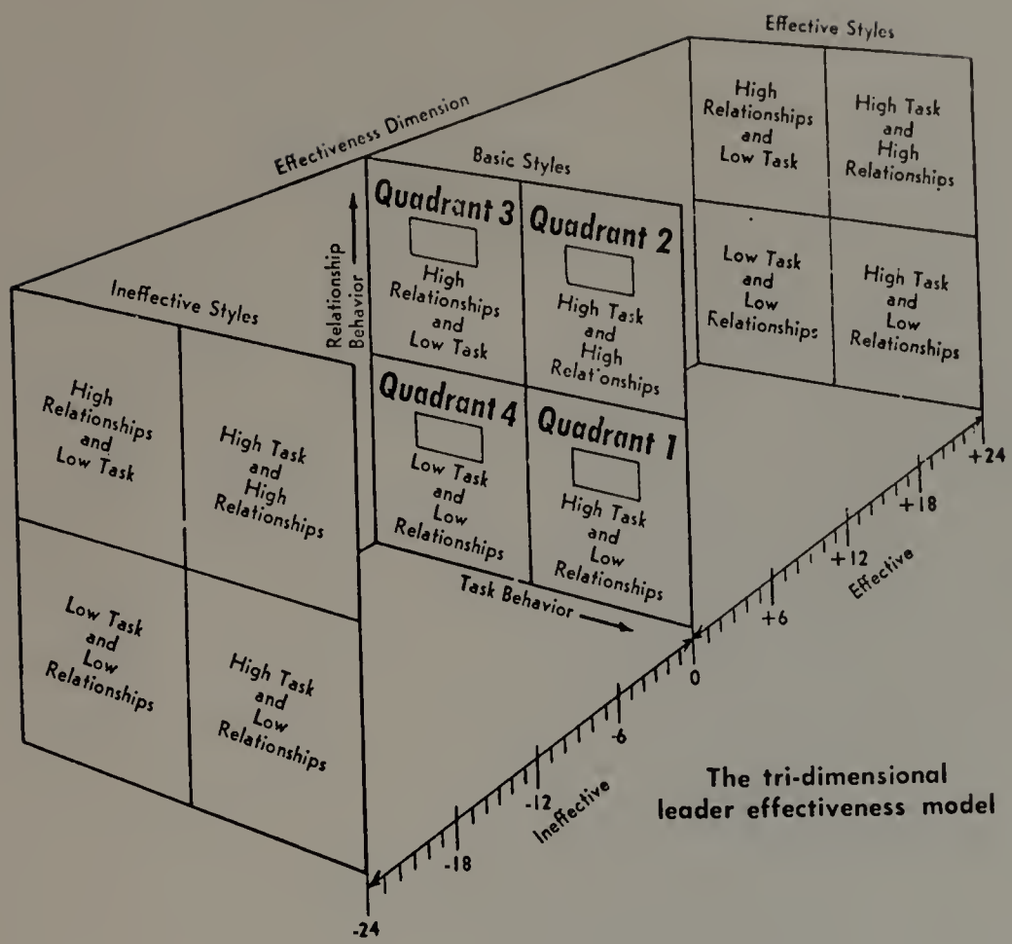
Then place an arrow (↖) at the corresponding number along the ineffective or effective dimension of the leadership model to the right.

Adapted from Hersey, P. and Blanchard, K. H. Leader Adaptability and Style Inventory.

SITUATIONS	COLUMN I (Style Range) Alternative Actions				COLUMN II (Style Adaptability) Alternative Actions			
	(1)	(2)	(3)	(4)	(a)	(b)	(c)	(d)
1	A	C	B	D	D	B	C	A
2	D	A	C	B	B	D	C	A
3	C	A	D	B	C	B	A	D
4	B	D	A	C	B	D	A	C
5	C	B	D	A	A	D	B	C
6	B	D	A	C	C	A	B	D
7	A	C	B	D	A	C	D	B
8	C	B	D	A	C	B	D	A
9	C	B	D	A	A	D	B	C
10	B	D	A	C	B	C	A	D
11	A	C	B	D	A	C	D	B
12	C	A	D	B	C	A	D	B
Sub-columns	(1)	(2)	(3)	(4)	(a)	(b)	(c)	(d)

Multiply by:			
(a) -2	(b) -1	(c) +1	(d) +2

	+		+		= TOTAL



The tri-dimensional leader effectiveness model

APPENDIX I

OUTLINE OF INFORMATION GIVEN TO HEAD NURSES, NURSING STAFF AND NURSING SUPERVISORS

The outline below was followed by the investigator with each of the three groups contacted in the two agencies.

1. Request for participation
2. Purpose of study
3. Participant's time involvement in study
4. Anonymity of participants in study
5. Personal Data Sheet/Permission Form
6. Reporting of Results to participants in study

APPENDIX J

Table A. Distribution of Sample by Position, Mean Age and Mean Length of Time in Position

Nursing Staff	Agency A		Agency B		Combined		Agency A Mean	Agency B Mean	Combined Mean	Agency A Mean	Agency B Mean	Combined Mean
	#	%	#	%	#	%						
Head Nurse	10	13	12	11	22	12	45.2	42	43.6	8.4	4.7	6.3
Registered Nurse	37	49	37	33	74	41	32.9	32.2	32.5	4.1	4.3	4.2
Licensed Practical Nurse	14	19	33	30	47	24.5	35.4	35.6	35.5	4.7	6.0	5.4
Aide/Orderly	11	15	25	22	36	18.5	45.1	31.5	38.3	8.8	3.4	6.1
Supervisor	3	4	4	4	7	4	51	52	51.5	14.3	9.2	11.8
All Combined	75	40	111	60	186	100	41.9	38.6	40.3	8.1	5.4	6.7

APPENDIX K

Table B. Summary of Analysis of Variance for LEAD-Other

	Agency A			Agency B			Between Agencies		
	df	F	p	df	F	p	df	F	p
High Task, Low Relationship	9/52	1.17	.33	11/84	3.55	.001	1/156	3.94	.05
High Task, High Relationship	9/52	6.15	.001	11/84	1.90	.05	1/156	.58	.45
High Relationship, Low Task	9/52	2.39	.05	11/84	3.11	.01	1/156	.37	.55
Low Task, Low Relationship	9/52	7.08	.001	11/84	1.63	.10	1/156	2.91	.10
Effectiveness	9/52	2.62	.05	11/84	2.60	.01	1/156	.74	.40