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THE RELATIONSHIPS OF LEADERSHIP BEHAVIORS, OPTIMISM, AND COPING IN HEAD NURSES

A Thesis

Presented for the

Master of Science in Nursing

Degree

The University of Tennessee, Knoxville

Melissa Morris-Justice

May 1991

DEDICATION

This thesis is dedicated to the memory of my father

Amos William Morris

who believed in me when I did not believe in myself.

His strength dwells in my heart and has served as

the impetus for completion of this thesis.

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ABSTRACT

Head nurses are the front-line managers of nursing units and are therefore responsible for the effective and efficient functioning of those units. What leadership behaviors are necessary for them to competently perform their jobs? Does the possession of certain qualities, such as optimism and the use of specific coping strategies enhance their leadership abilities? These questions were investigated at The University of Tennessee, Knoxville, during a two-year period, from fall 1989 through Spring 1991. Data was collected December 1990 through January 1991 on head nurses in the Knoxville area hospitals. The sample of head nurses completed a demographic data sheet, Life Orientation Test instrument, and the Jalowiec Coping scale. The head nurse's immediate supervisors completed the Leadership Behaviors instrument. The Pearson product-moment correlation was computed on the scores derived from instrumentation results. Data analysis was be performed using the Statistical Analysis System (SAS).

No significant relationship was found to exist between leadership behaviors, optimism, and coping. There was a significant correlation between the confrontive coping subscale and optimism. Another finding of the study was the relationship between leadership behaviors and years of experience as a head nurse.

The effectiveness of leadership behaviors increases with years of experiences of the head nurse. However, there was no relationship between the age of the nurse and leadership behaviors.

Health care institutions need to focus their efforts on retention of head nurses. One way to increase retention is to provide a comprehensive

orientation period for head nurses. Hospital administration should provide an atmosphere conducive to professional growth and support. Lastly, nurses must take responsibility for mentoring their colleagues.

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LIST OF ABBREVIATIONS

Leadership Behaviors	LB
Jalowiec Coping Scale	JCS
Life Orientation Test	LOT
Associate Degree in Nursing	ADN
Baccalaureate Degree in Nursing	BSN
Masters of Science in Nursing	MSN
Masters Degree of Arts	MA

CHAPTER I

INTRODUCTION

Increasing patient demands for nursing care amidst dwindling numbers of nurses to meet those demands, tighter budgeting control of nursing units, and demands on nurses to constantly acquire new knowledge while maintaining existing skills have led to low morale and "burn-out" in nurses. Hein & Nicholson (1986) suggest that there is an urgent need for vital nursing leadership. The nursing profession is possibly suffering from the most severe shortage since its inception. The nursing shortage coupled with shrinking budgets and increasing demands to update knowledge bases has added to the burdens of nursing leadership.

The healthcare industry has been bombarded with a deluge of increasing technological advancements. Almost as quickly as one type of equipment is marketed, it is obsolete. The quest to continually stay abreast of new developments is an ever present challenge for nurses.

This quest for knowledge related to technology has interfered with the most important quality of nursing. That quality is the ability to successfully interact with other human beings and to establish meaningful interpersonal relationships. It is not enough that we, as nurses, establish therapeutic interpersonal relationships with our patients, we must extend the development of interpersonal relationships to our coworkers. This is especially true of the head nurse whose successful job performance requires effective interaction with his/her nursing staff.

This establishment of a good interpersonal relationship with coworkers is the hallmark of successful leadership in nursing. Leadership

does not exist in a vacuum. Before leadership can exist there must be a followership (Sullivan & Decker, 1985; Hein & Nicholson, 1986). Sullivan & Decker (p. 132) define leadership as, "the use of one's skills to influence others to perform to the best of their ability". The "use of one's skills" suggests that the performance in the leadership role is affected by individual intrapersonal qualities. Each individual has certain inherent traits that affect their leadership.

Head nurses are confronted with the challenge to problem-solve on a minute-to-minute basis. The ability to quickly face problems and actively work toward a successful outcome is consistent with Scheier & Carver's (1985) definition of inherent dispositional optimism. Dealing with problems is accomplished through the use of coping strategies. Nursing leaders must have the ability to cope with constantly changing situations. Variation in the ability to successfully problem solve raises the question of how coping strategies and level of optimism might relate to effective leadership. In addition to coping strategies and optimism, the problem solving process in head nurses may be related to years of experience, age, and education.

The identification of specific intrapersonal traits in effective nursing leaders, has favorable implications for the nurturance and cultivation of these attributes in prospective leaders. Favoring of certain coping strategies and high levels of dispositional optimism may be among the traits associated with effective nursing leadership. In view of the problems confronting nursing today, effective leadership is the most valuable resource within the profession and the factors associated with it deserve further investigation.

Purpose of the Study

The purpose of the study was to investigate the relationship between leadership behaviors, types of coping strategies, and levels of dispositional optimism in head nurses

Significance of the Study

Head nurses are in an important leadership position within the hierarchy of nursing administration. They must be able to effectively and efficiently assimilate information, assist with goal setting, and facilitate goal attainment within their respective units of practice. They are responsible for decisions which affect patient care, nursing staff, and administration. They act as liaison between staff and hospital administration.

The identification of intrapersonal traits associated with effective leadership in nursing would be helpful. The employment of certain types of coping strategies or high levels of dispositional optimism may allow the leader to deal with stressors more effectively. Optimism gives the individual the ability to anticipate that problems can be solved. Coping facilitates the process of problem-solving.

If specific intrapersonal traits could be identified as desirable in head nurses, their assessment could serve as a basis for an appraisal tool to assess prospective candidates for the leadership role. If desirable traits were identified, nursing education could include strategies to nurture and develop these traits in students.

The nurturance and cultivation of prospective leadership candidates

would strengthen nursing leadership in the future. The study of factors that enhance nurses' leadership behaviors is a worthy endeavor. Findings from such a study will provide healthcare workers with information about factors that influence head nurses' effectiveness as leaders.

Conceptual Framework

Management and leadership are terms that are often used interchangeably, but they have distinct and different meanings. Management refers to the coordination of resources to accomplish goals. Leadership refers to the use of interpersonal relationships with followers in order to set goals and attain those goals. A leader can be a manager and a leader. A manager may or may not be an effective leader depending on whether the manager possesses interpersonal skills that inspire followers.

While there are many theories of leadership that attempt to conceptualize this relationship, many do not fit well with nursing. Yura's conceptualization was designed specifically for nursing. Therefore, it is more applicable to, and consistent with, nursing leadership behaviors.

The major foundation for this study is Yura's (1970) concept of leadership behaviors. Yura defines leadership behaviors by subdividing them into components of self, critical thinking and decision-making, interpersonal relationships, group relations, and job relations. These components are closely interrelated.

The concept of self represents the leader's insight into his/her self as a person, with attitudes, motives, strengths, and weaknesses (Yura, 1970). This insight into self encompasses perceptions of inherent intrapersonal

traits and recognition of self-acceptance, creativity, adaptability, and sensitivity to the responses of others to self. The definition of self is extended to include the leader's ability to function in situations with self control and self direction (Yura, 1970). Several of Yura's components of leadership behavior suggest that the use of certain coping strategies and the level of dispositional optimism may be related to effectiveness as a head nurse. The way a person perceives a problem can influence the coping strategy the individual chooses to use. The use of certain coping strategies may affect the head nurse's effectiveness in the leadership components related to interpersonal relationships, group relations, and job relations. An individual's use of confrontive, self-reliant, and optimistic coping would seem to be facilitated by higher levels of dispositional optimism that permit problems to be more quickly identified so that a solution can be sought more persistently. Levels of dispositional optimism may relate to a preference for using certain coping strategies.

Dispositional optimism is not a learned response but is an inherent trait, a part of the "self" component of Yura's model. This intrapersonal attribute is thought to be related to both effective coping and problem solving. An individual with a high level of dispositional optimism more often anticipates a favorable outcome when faced with a stressor or problem (Scheier & Carver, 1987). They are more likely to interpret obstacles as something that can be overcome, making them more successful in dealing with stressors (Scheier & Carver, 1985). If a person expects a favorable outcome he/she may face the problem sooner and work more persistently to achieve the outcome.

Yura's concept of critical thinking and decision making describes the behavior on the part of the leader that is an action taken toward finding

solutions to problems. The solution to problems is based on the individual leader's effectiveness, .creative thinking, and decision-making (Yura, 1970).

Interpersonal relationships are based on leader-follower relationships rooted in an awareness of sensitivity to feelings, thoughts, needs, and reactions of others. Yura (1970) conceptualizes the leader as considerate, tolerant, and an effective communicator who also displays strength of conviction, forcefulness, and persistence.

Yura's concept of group relations involves the leader's relationship with the group members (followers) toward goal setting activity (Yura, 1970).

The concept of job relations involves the leader as a facilitator of work. The leader functions as a competent practitioner, capable of delegating responsibility, planning and utilizing the resources and talents of co-workers in an efficient and effective manner, so that task completion and goal attainment are achieved (Yura, 1970).

Statement of the Problem

Major Research Questions

1. What is the relationship between leadership behaviors and optimism in head nurses?
2. What is the relationship between leadership behaviors and coping strategies?
3. What is the relationship between optimism and coping strategies?

Subsidiary Research Questions

4. What is the relationship between leadership behaviors and years of experience as a head nurse?

5. What is the relationship between leadership behaviors and age of the head nurse?

6. What is the relationship between leadership behaviors and education of the head nurse?

Nominal Definitions

1. Head Nurse - a registered nurse with direct responsibility for the management of a nursing unit. This responsibility involves the management of personnel, rendering of quality patient care, and management of resources for the nursing unit. The head nurse has a 24 hour responsibility for the unit under his/her direction.

2. Supervisor - a registered nurse who is the head nurse's immediate superior on the institution's organizational chart. The supervisor works closely with the head nurse and has knowledge of the head nurse's leadership behaviors.

Operational Definitions

1. Leadership Behaviors - the head nurses ability to effectively demonstrate behaviors that are reflective of concepts of self, critical-thinking and decision making, interpersonal relationships, group relations with staff and administration, and job relations for task completion and goal attainment as perceived by their supervisors and

measured by the Leadership Behaviors (LB) instrument.

2. Optimism - Level of inherent dispositional tendency toward optimism as measured by the Life Orientation Test (LOT).

3. Coping - The head nurse's use of strategies reflective of confrontive, emotive, evasive, supportant, optimistic, fatalistic, palliative, and self-reliant coping as measured by the Jalowiec Coping Scale (JCS).

Assumptions

1. All head nurses demonstrate leadership behaviors in their role.

2. Every head nurse uses coping strategies, but the strategies most often used differ between individuals.

3. All head nurses have some measure of optimism, whether the level is low or high.

4. The instruments are valid measurements of leadership behaviors, types of coping used, and levels of optimism.

5. The head nurses and supervisors answered the questions with honesty and objectivity.

CHAPTER II

REVIEW OF LITERATURE

Introduction

The concept of leadership and why certain persons are successful leaders have been questioned throughout most of recorded history. The previously held assumption was that leaders were born and not made (Kreitner, 1989) and early concepts of leadership focused on inherent, or inborn, capabilities of leaders. A few impressive examples of leaders come to mind; Abraham Lincoln, Martin Luther King, and Napoleon Bonaparte.

In the twentieth century, with the advances in behavioral sciences, the concept of leadership began to change. The belief that leaders were simply born diminished and a great interest in traits of leaders started to emerge. The springboard for this concept was the hypothesis that leadership could be acquired through knowledge and experience. Experience helps to increase the leaders knowledge of the role and may facilitate more effective leadership behaviors.

Today leadership is viewed as situational. Many theories of leadership behaviors have been presented utilizing this situational concept (Fielder, 1967; House & Mitchell, 1974; Vroom & Yetton, 1973).

Leadership Behaviors in Nurses

The quest for identification of certain themes in leadership has spurred researchers in an attempt to analyze demographic characteristics in nursing leaders. Bullough, Bullough, and Wu (1989) completed a retrospective comparative study of historical figures dominant in nursing between 1870 and 1940. The sample included 175 women and two men. The purpose of the study was to look for commonalities in the backgrounds of these historical nurse leaders. The findings revealed that the group tended to be well educated, from the Eastern Seaboard, from middle to upper class, and educated at Columbia University Teacher's College. Coincidentally, all of the group were marked by extended longevity.

In keeping with the concept of situational leadership, Sheridan (1984) postulated that leadership can only be explained within the work context in which the leader exhibits the behavior. Therefore, studies that focused on the leader-follower interrelationship in the work setting would offer the most useful findings.

A study in the work setting by Peck (1988) investigated head nurse "fit" with staff, administration, and situation, and its impact on unit performance and staff satisfaction. Twenty-five assistant directors of nursing, 87 head nurses, and 296 staff nurses participated in the study. Assistant directors of nursing were interviewed to determine the level of performance of staff on units and cite why they felt certain units performed well. Head nurses and staff nurses completed questionnaires related to unit performance, staff satisfaction, and "fit" between the head nurse and staff. All assistant directors identified the head nurse as the key

influencing factor in unit performance with fit and matching of styles of personalities, and circumstances as important variables. A relationship style of leadership was associated with units that performed well.

Head nurses using this relationship style of leadership were described as having good relationships with their staff and as able to communicate well with staff. Further, head nurses with relationship-oriented leadership had a positive linkage between their supervisors and subordinates. Staff satisfaction was associated with positive linkages between head nurse and his/her supervisor.

McCloskey and McCain (1988) were interested in evaluating performance of staff nurses under the direction of different head nurses. The Six Dimension Scale of Nursing Performance was used to measure staff nurses' skills in the areas of professional development, interpersonal relations/communication, critical care, leadership, planning/evaluation, and teaching/collaboration.

Although not the focus of the study, they noted that older head nurses gave higher performance ratings to their staff. This finding led to the recommendation that more research be done on the relationship of head nurses' age and staff nurses' performance. A question raised from this research was "do older head nurses, in fact, know their job better and elicit better performance from their staff nurses or, with age, do their standards for evaluation become more tempered" (McCloskey & McCain, p. 312).

Duffield (1989) used a panel of nursing experts to identify the most important competencies of head nurses. These nursing experts were provided with a list of 168 competencies the first-line manager (head nurse) is expected to have and were asked to cite 20 they believed to be most important. The findings were reflective of the idea that first-line managers

are the link between management and patient care and two of the three items ranked most important related to patient care. Acting as a resource person, maintaining a favorable work environment, organization of the nursing unit, quality assurance, participative decision-making, staff development, maintenance of morale, and budgeting were all cited as important competencies.

The functions sited in Duffield's study represent a slightly different perspective than that of an earlier study by O'Connor (1982). In O'Connor's study 132 nursing leaders were asked to describe behaviors in actual situations in which they felt particularly effective or ineffective in some aspect of the leader role. They were asked to cite two effective and two ineffective behaviors.

The sample consisted of deans or department chairs of collegiate nursing programs, faculty, continuing education directors in hospital and college settings, staff development directors in hospitals, directors or administrators in hospitals and home health agencies, and clinical specialists in hospitals. All of the participants were educated at the graduate level. The responses contained 462 usable incidents. Fifty-two percent (299) of the incidences cited described effective behaviors and 274 (48%) ineffective behaviors. The analysis of the responses revealed that nursing leadership behaviors critical to the enactment of effective leadership role clustered in the areas of communication, performance evaluation, teaching practices, management practices, problem solving, conflict management, self-esteem, change process, political savvy, group processes, role modeling, and crisis intervention.

These functions demonstrate an extensive repertoire of activities the nurse leader must be able to successfully orchestrate in day-to-day

leadership behaviors. The head nurse must be diverse, creative, and innovative.

Adams (1988) examined the relationship between creative style and leader behavior in chief nurse administrators (CNAS). The sample was 66 CNAS from acute care hospitals in five counties in the San Francisco Bay area. The Kirton Adaptation-Innovation Inventory (KAI) and the Leader Effectiveness and Adaptability Description-Self (LEAD-S) and demographic tools were used. The findings of the study showed that CNAS were innovative thinkers but their innovative behavior was not related to their leader effectiveness. Years of experience was, however, predictive of leader effectiveness.

Optimism

Some persons tend to be more optimistic by "nature". This sense of optimism tends to span their entire philosophy of life. Optimism represents the ability to interpret events as manageable. Scheier & Carver (1985) suggest that optimism allows a person to anticipate that things will go their way and take action to effect such an outcome. The concept of optimism can be defined as the anticipation of a favorable outcome. According to Scheier & Carver (1985) the individual who has a higher level of optimism is more likely to employ certain healthy coping strategies. Optimistic persons are more likely to interpret impediments facing them as being something that can be overcome. This perception should cause them to be more successful in dealing with stressors (Scheier & Carver, 1985). Studies have investigated the relationship between optimism and health outcomes. Scheier & Carver (1987) conducted a study of college students to explore the

impact of dispositional optimism in a health related context. Students made-up the sample and were tested the last four weeks of the semester, presumed to be the most stressful. Subjects completed the Life Orientation Test (LOT) and the physical symptom checklist initially, and again in four weeks on the last day of class. The findings revealed that optimism was negatively correlated with symptom reporting at both assessment periods.

Additional research by Scheier & Carver (1985) focused on optimism, physical symptoms, and hostility. The Life Orientation Test (LOT), the Cook-Medley Hostility scale, and the physical symptom checklist were administered to 103 undergraduate students. Four weeks later, at the semesters end, the physical symptom checklist was readministered. Optimism was inversely related to hostility. Both were related to physical symptoms with optimism negatively correlated and the hostility positively correlated.

Scheier, Matthews, Owens, Abbott, Lebfevre, & Carver (1986) explored the levels of physical well-being of coronary artery bypass surgery patients. The patients were contacted at three different times. The first contact was the day before surgery, the second contact was six to eight days following surgery, and the third six months following surgery. The Life Orientation Test was administered during the first contact to assess dispositional optimism.

At six to eight days after surgery optimists were judged by the cardiac rehabilitation team to show faster recovery ($p < .02$) than were pessimists. Review of the medical record indicated that optimists recovered more quickly and were less likely to develop Q wave changes in their EKG than were pessimists. Additionally, optimists showed less clinically significant release of SGOT during surgery. Prior to surgery optimists were

more likely to be setting goals for their recovery period and were less likely to be dwelling on negative aspects of their emotions such as feeling nervous or sad. At six months post-operatively there was a strong correlation between optimism and self reported quality of life.

While optimism appears to facilitate health outcomes, there may be negative connotations to being overoptimistic. Tennen & Affleck (1987) warned that when things go wrong the optimist may be particularly vulnerable. Optimistic persons may realize that bad things happen to people but may not perceive that bad things can happen to them. Therefore, they may be unprepared psychologically to handle adverse outcomes adequately.

The anticipation of a successful outcome should facilitate problem-solving capabilities. The expectation of a successful outcome might cause the individual to work harder and with more persistence to attain this favorable outcome. Persons higher in dispositional optimism may deal with problems sooner than persons lower in optimism (Scheier & Carver, 1985).

Silver (1986) supports the idea that optimistic people tend to view stressors as being only temporary. The stressor, or problem, is specific and does not affect every aspect of their life. Further, the stressor is seen as something external.

Coping

The process of coping occurs when a stressful situation is encountered that evokes feelings of distress. When the stressor is encountered it must be assessed and a decision must be made about how to

psychologically deal with the situation. A determination must be made about possible avenues through which the stressful situation can be eliminated, minimized, or circumvented.

The coping process differs among individuals. Differences in the way an individual uses coping strategies depend on: 1) the perceived threat of the stressor to integrity; 2) past exposure to similar stressors; 3) past successful or unsuccessful ways of coping with the stressor; and 4) outcome expectancies.

A person may utilize one particular type of coping strategy or a combination of strategies interchangeably. Jalowiec (1983) defined coping strategies as being either problem-oriented or affective-oriented. The use of a problem-oriented strategy refers to the attempt on the part of the individual to deal with the stressful situation itself. The affective-oriented strategy refers to the attempt to control the distressing emotions evoked by the situation (Folkman & Lazarus, 1980; Jalowiec, 1983).

Problem-focused coping is more likely to be utilized when a person has the belief that the stressor can be managed successfully. Conversely, emotion-focused coping may be employed when a person perceives the stressor as one that must be endured (Folkman & Lazarus, 1980). Scheier and Carver (1985) state that problem-focused coping is an attempt by the individual to do something that will facilitate movement toward the goal with which the stressor is interfering.

Scheier, Weintraub, & Carver, (1986) conducted two studies to examine optimism as a predictor of adaptation to stressful encounters. In the first study, subjects were asked to recall a stressful event and indicate how they attempted to cope with the situation using a self-report scale. In the second study, subjects were given a set of hypothetical situations and

were asked how they would cope with the situations. In both studies optimism was measured by the Life Orientation Test (LOT). In both studies optimism was positively correlated with problem-focused coping strategies of seeking social support and emphasizing positive aspects of the stressful situation.

Wikoff & Miller (1988) conducted a study of 210 spouses of cardiac surgery patients to examine coping strategies. The subjects were asked to complete the Jalowiec Coping Scale. The findings reflected the use of three coping factors. The first was confrontive indicating a problem-solving approach. The second factor was palliative in that problems were dealt with in a passive way. The third factor was emotive indicating that subjects dealt with problems in an emotional way.

Hu (1989) explored the concepts of social support and coping strategies most used by critical care patients. The findings indicated that the most frequent source of social support was family or relatives. The most frequently used coping strategy was problem-focused.

The results of the study suggest that persons utilizing problem-focused strategies to cope with problems can also benefit from supportant emotive-focused coping. Therefore, one or more strategies can be used simultaneously and interchangeably.

Summary

Many attempts have been made to identify factors related to leadership. There are, however, few available studies investigating the relationship between intrapersonal traits of the individual leader and his/her effectiveness in the leadership role.

Interpersonal relationships of the leader and follower are rooted in the personal traits and attributes that each individual brings with them to the relationship. To state this more succinctly, research must go beyond the interpersonal relationship itself and delve into intrapersonal traits of the individuals assuming leadership roles.

CHAPTER III

METHODOLOGY

Design of the Study

The study was a correlational, descriptive study of the relationships between the variables of leadership behaviors, use of specific coping strategies, and optimism.

Instrumentation

Leadership Behaviors

Leadership behaviors were measured using the Leadership Behaviors instrument (Appendix B). This scale was originally developed to measure faculty perceptions of baccalaureate nursing students' behavior indicative of leadership potential (Yura, 1970). The researcher determined that the scale was appropriate to measure leadership behaviors in head nurses because they have surpassed the student role and are functioning in positions of formal leadership within the hospital structure.

Before its original use, the instrument was reviewed by a panel of experts. It consists of 70 items with a response scale of 1-4. The numerical value of zero indicates that the head nurse's performance of that leadership behavior is adequate. A rating of fourindicates that the head nurse's performance for that leadership behavior is outstanding. The scale is divided into five subscales related to the concepts self, critical thinking and decision-making, interpersonal relationships, job relations, and group

relations. The questions were judged to be clear with a readability level appropriate for the sample. Limited testing indicated completion of the questionnaire takes approximately 20 minutes.

Dispositional Optimism

Dispositional optimism was measured using the Life Orientation Test (Appendix C). This instrument consists of eight items, plus four fillers. The reading level for the instrument is at a 5.2 grade level. Completion of the questionnaire takes approximately 10-20 minutes. The instrument uses a Likert-type scale asking the respondent to indicate the degree to which he/she agrees or disagrees with the statement. Previous testing revealed the Cronbach's alpha for the entire scale to be .76. The test-retest correlation was .79 for a combined sample of 81 men and 61 women with the time interval of four weeks (Scheier and Carver 1985). This instrument has been utilized in several studies and the reliability and validity are consistent.

Jalowiec Coping Scale

The Jalowiec Coping Scale (Appendix E) was used to measure the use and effectiveness of certain types of coping styles. The instrument is divided into subscales of coping strategies which include: 1) confrontive; 2) evasive; 3) optimistic; 4) fatalistic; 5) emotive; 6) palliative; 7) supportant; and 8) self-reliant.

For the study only the use of coping strategies was investigated. The central focus for the study was the relationship between leadership and the use of coping strategies. Therefore, coping effectiveness was not investigated.

The instrument consists of 60 items scored on a Likert- type scale ranging from 0-3. The numerical value of zero indicates that the coping method was never used and three indicates the coping method was used often. The readability level was appropriate for the sample. Completion of the questionnaire takes approximately 15-20 minutes.

The scale was revised in 1987 from an earlier version of the Jalowiec Coping Scale and psychometric data is still being collected on the revised instrument. Jalowiec (1989) presented statistical data on reliability from two studies that utilized this instrument. The first study involved cardiac transplant patients and produced satisfactory Alpha reliabilities for all subscales except fatalistic and palliative. Cronbach Alpha reliability score for three retest periods in the cardiac transplant group for total use scores was .78, .61, .82. The second study involved elderly widows/widowers and produced satisfactory Alpha reliabilities on all subscales except palliative and self-reliant, with Cronbach Alphas in the use subscales of confrontive = .96, evasive = .91, optimistic = .91, fatalistic = .74, emotive = .80, supportant = .78.

A demographic data sheet (Appendix D) was designed by the researcher. This instrument included age, sex, marital status, education, years of clinical nursing experience, and years of experience as a head nurse. Blank spaces following each variable were provided that required the insertion of a check mark or a numerical value.

The Leadership Behaviors instrument (LB), the Jalowiec Coping Scale (JCS), and the Life Orientation Test (LOT) were all copyrighted instruments. Written permission was obtained from Dr. Helen Yura-Petro

for the use of the LB, from Dr. Michael Scheier for use of the LOT, and from DR. Ann Jalowiec for the use of the JCS.

Scoring of Instruments

Relative scores were used on the Jalowiec Coping Scale (JCS) and the Leadership Behaviors (LB) instruments. Statistical computation of relative scores on instruments with subscales is advantageous because it controls for unequal numbers of questions on each subscale and it allows for individual differences in response rates (Vitaliano, Mauiro, Russo, & Becker, 1987; Jalowiec, 1989). By using this method, how much of the total coping effort is put into each type of coping can be determined. Further, Jalowiec (1989) states,

> "relative scores have both an ipsative and normative frame of reference; ipsative because the person serves as his/her own standard of comparison; normative because the score allows for a common basis of comparison across subjects".

Relative scores are calculated by obtaining the mean scores on each subscale and then dividing the mean of one subscale by the total means of all subscales. The following equation is an example:

$$\frac{\text{(LB) Self mean}}{\text{Self mean + Critical Thinking mean + Interpersonal Relationship mean + Group mean + Job mean}}$$

Subjects

The sample for the study was a convenience sample of 60 head nurses and their supervisors. All of the subjects were employed by Knoxville area hospitals. One-hundred and one head nurses and 22 supervisors were asked to participate. The sample population of head nurses (n=60) had a mean age of 40.05 years. Ninety-five percent of the population were females and five percent were males.

Eighty percent were married and living with their spouse, while 3.3 percent had never been married, and 16.7 percent were separated or divorced. Fifty percent of the sample cited their educational level as diploma preparation. Educational levels are summarized in Table 3.1.

In this group of head nurses only two groups of colleagues worked closely enough with the head nurses to adequately appraise their performance. These two groups were the staff nurses working under the direction of the head nurses or the head nurses' immediate supervisors. The supervisors were selected to evaluate the head nurse because the researcher believed they could be more objective in their evaluation. Most supervisors have worked in positions from staff nurse to supervisor and have had exposure to many head nurses with varied leadership styles. Supervisors usually have more than one head nurse working under their direction, giving thema more objective basis for comparison.

Table 3.1 Summary of educational level (n=60)

Education	Frequency	Percentage
A.D.N.	5	8.3
Diploma	30	50
B.S.N.	14	23.3
B.A.	2	3.3
Other Baccalaureate Degree	2	3.3
M.S.N.	5	8.3
Other Masters Degree	1.0	1.7
Other education	1.0	1.7

Matched sets of data from the head nurses and their supervisors were needed for statistical analysis. There was a 84 percent response rate from the head nurses and a 76 percent response rate from the supervisors. A sample size of 60 was obtained.

In order to participate in the study, subjects had tomeet the following criteria:

1. Be willing to voluntarily participate in the study.
2. Be employed in one of the hospitals that gave written permission for data collection.
3. Be a Registered Nurse.

The sample included only those nurses that consented to participate and signed a consent form. Data collection lasted from December 1990 through January 31, 1991.

Procedure

Prior to the collection of data, the researcher received written permission for the project from the Human Subjects Committee of the College of Nursing and the The University of Tennessee and from participating hospitals.

The author of the Leadership Behaviors instrument did not include an estimation of the time required time for

completion. Therefore, a pilot study was conducted with six Registered Nurses. The time required to complete the instrument was 5-20 minutes.

After receiving a list from each hospital of their supervisors and head nurses, a convenience sample of 101 head nurses and 22 supervisors was selected. Code numberswere assigned to subjects. Only the researcher knew the identity of the participants.

The head nurses were asked to complete three instruments and a consent form. These instruments included the demographic data sheet, the Jalowiec Coping Scale (JCS), and the Life Orientation Test (LOT). Completion of the entire packet was estimated to take 45 minutes.

The supervisor of each participating head nurse was asked to complete a consent form and the Leadership Behaviors (LB) instrument evaluating each participating head nurse under her supervision. This instrument was used as an appraisal tool with scores indicating the extent to which, in the supervisor's opinion, the head nurse demonstrated leadership behaviors. It must be noted that any type of appraisal instrument seeking someone's perception of another person's performance is subjective and therefore biased.

The instruments were professionally printed and compiled in booklets for subject convenience. Each packet contained an ink pen and was placed in a self-addressed, stamped envelope so that the packets could be returned directly to the researcher. All packets were assigned a code number to protect confidentiality.

Personal contact with subjects was believed, by theresearcher, to increase the return rate of packets. Data collection techniques included: 1)introduction and personal contact when possible; 2) a brief explanation of the study; 3) instructions for completion and return mailing of the packets to the researcher; 4) phone numbers and address of the researcher in the event additional questions arose; 5) a brief presentation of the researcher's

perceptions of the study's contribution to nursing. An extra attempt was made to increase the return rate by sending a follow-up letter of reminder if the packets had not been returned in two weeks following their distribution.

Data Analysis

The Life Orientation Test, Jalowiec Coping Scale, and the Leadership Behavior Scale all utilized a Likert-type scale. Therefore, all data was equal appearing and was treated as interval data. Comparison of variable scores was accomplished through statistical analysis using Statistical Analysis System (SAS) software. The mean for measure of central tendency, standard deviation for measure of variation, and the Pearson Product Moment Correlation (r) for test of relationships were used (Brink and Wood 1988).

The data was analyzed using predetermined limits on Cronbach's Alpha for reliability. An acceptable Cronbach's Alpha on each subscale of the LB and JCS and LOT was >.70. Statistical analysis was performed using a significance level (p) of less than or equal to .05.

Demographic variables were collected. Years of experience as a head nurse and age of head nurses were correlated with Leadership Behaviors (LB). Initial tabulations of instrument scores were made and cross-tabulations were described on tables.

Limitations which exist and could not be controlled for are:

1. Supervisors' appraisal of head nurses was subjective and biases may have existed.
2. Coping use scores could have been influenced by the number of subordinates the head nurse had working under his/her direction.

3. The type of unit the head nurse was responsible for leading could have influenced coping use scores. (example: The Intensive Care Unit is more stressful than an Ambulatory Care Unit)

4. Previous exposure or familiarity with the instruments could have produced biases and influenced the reliability of the instruments.

CHAPTER IV

RESULTS

Introduction

The following chapter is a discussion of the statistical findings of the study. Reliability of the instruments is discussed and displayed in tables. Correlation co-efficients are displayed in tables that answer both the major and subsidiary research questions.

Reliability of Instruments

The Leadership Behaviors (LB) instrument consists of 70 items and is divided into five subscales of: self, critical thinking and decision-making, interpersonal relationships, job relations, and group relations. The total Leadership Behaviors (LB) instrument was analyzed for reliability using Cronbach's Alpha. Reliability for the total instrument was .97. Each subscale was analyzed for reliability using Cronbach's Alpha (Table 4.1). Subscale reliabilities ranged from .878 to .921.

The sixty item Jalowiec Coping Scale is divided into eight subscales of: confrontive, evasive, optimistic, fatalistic, emotive, palliative, supportant, and self-reliant. The total Jalowiec Coping Scale was analyzed for reliability using Cronbach's Alpha.

Table 4.1 Summary of reliability on subscales of LB (n=60)

Subscales	Cronbach's Alpha
Self	.921
Critical Thinking and Decision-making	.899
Interpersonal Relationships	.905
Group relations	.905
Job relations	.878

Reliability for the total instrument was .76. Each subscale was analyzed for reliability using Cronbach's Alpha (Table 4.2). An acceptable Cronbach's Alpha had been previously determined to be .70. Cronbach Alphas for optimistic, self-reliant, fatalistic, emotive, palliative, and supportant subscales were less then .70. Only reliabilities of confrontive and evasive coping subscales had Cronbach Alphas >.70. Analysis of coping strategies was limited to these two subscales. Other subscales had reliabilities <.70 which ranges from .32 to .52, therefore these subscales could not be used in the analysis of data.

The Life Orientation Test was analyzed for reliability using Cronbach Alpha. The reliability of the instrument was .77. The reliability of .77 is consistent with Scheier and Carver's (1985) earlier findings of .76.

Results

The first research question addressed the relationship of leadership behaviors and optimism. Data used to address the research question included: 1) scores on the subscales of the Leadership Behaviors (LB) instrument and 2) scores for the Life Orientation Test (LOT). Analysis using Pearson Product Moment Correlations revealed no significant relationship between any of the subscales of leadership behaviors and optimism. (Table 4.3)

Table 4.2 Summary of Cronbach's Alpha on subscales of the JCS (n=60)

Subscales	Cronbach's Alpha
Confrontive	.742
Evasive	.737
Optimistic	.508
Fatalistic	.491
Emotive	.342
Palliative	.432
Supportant	.317
Self-reliant	.524

Table 4.3 Correlation co-efficients of LB and LOT (n=60)

LB Subscales	LOT
Self	r=.04, p=.78
Critical Thinking and Decision-making	r=.04, p=.78
Interpersonal Relationships	r=.01, p=.88
Job Relations	r= -.02, p=.87
Group Relations	r= .12, p=.34

The second research question addressed the relationship between leadership behaviors and coping strategies. Only the confrontive and evasive coping subscales had adequate reliabilities for analysis. The data used to address this question included: 1) scores from self, critical thinking, interpersonal relationships, job relations, and group relations subscales of the Leadership Behaviors (LB) instrument and 2) scores from confrontive and evasive coping subscales of JCS. Analysis using Pearson Product Moment Correlations revealed no significant relationship between the subscales of leadership behaviors and the confrontive and evasive coping subscales. Table 4.4 presents the correlation co-efficients of leadership behaviors and coping.

The third research question addressed the relationship between specific coping strategies and optimism. The data used in the analysis included: 1) scores on the confrontive and evasive coping subscales of the JCS and 2) scores of optimism on the LOT. Table 4.5 summarizes the correlation co-efficients of the confrontive and evasive subscales of the JCS and the LOT.

The interpretation of Table 4.5 indicates:

1. There is a significant relationship between optimism and the confrontive subscale of the JCS.
2. There is no significant relationship between optimism and the evasive subscale of the JCS.

Table 4.4 Correlation co-efficients of LB and JCS (n=60)

LB Subscales	Confrontive	Evasive
Self	r=.12, p=.35	r= -.16, p=.22
Critical Thinking and Decision-making	r= -.15, p=.25	r=.03, p=.80
Interpersonal Relationships	r=.04, p=.71	r= -.02, p=.87
Job Relations	r= -.01, p=.93	r=.17, p=.17
Group Relations	r=.03, p=.30	r=.003, p=.95

Table 4.5 Correlation co-efficients of JCS subscales and LOT (n=60)

JCS Subscales	LOT
Confrontive	r=.27, p=.04
Evasive	r=-.19, p=.37

The fourth research question addressed the relationship between leadership behaviors and years of experience as a head nurse. The total LB instrument and years of experience as a head nurse were statistically analyzed using Pearson Product Moment Correlations and no significant relationship was found. Further statistical analysis examining the five subscales of the LB instrument and self reported years of experience was performed. The information for correlation co-efficients is demonstrated in Table 4.6.

The interpretation of Table 4.6 suggests:

1. There is a significant negative relationship between the self subscale of the LB instrument and years of experience as a head nurse.
2. There is a significant positive relationship between the job relations subscale of the LB and years of experience as a head nurse.

The final question explored the relationship between leadership behaviors and age of the head nurse. Correlation co-efficients were performed on these variables. There was no significant relationship between the LB and age of the head nurse. ($r = -.03$, $p = .82$)

Table 4.6 Correlation co-efficients of LB and years of experience as a head nurse (n=60)

LB Subscales	Years of experience as head nurse
Self	r=-.28, p=.02
Critical thinking and decision-making	r=.10, p=.44
Interpersonal relationships	r=-.12, p=.33
Group relations	r=.01, p=.92
Job relations	r=.34, p=.006

Summary

Reliabilities of the Leadership Behaviors Instrument (LB) and the Life Orientation Test (LOT) were adequate but the reliabilities of subscales of Jalowiec Coping Scale were acceptable for only confrontive and evasive subscales. The confrontive and evasive coping subscales had Cronbach Alphas >.70 and were used in statistical analysis.

The analysis of data revealed no significant relationship between leadership behaviors and optimism, or leadership behaviors and coping. There was a significant relationship between the confrontive coping subscale and optimism. Further there were significant relationships between the self subscale and years of experience as a head nurse, and the job relation subscale of leadership behaviors and years of experience as a head nurse. Lastly, there was no significant relationship between leadership behaviors and age of the head nurse.

CHAPTER V

DISCUSSION AND SUMMARY

Introduction

The results of each major and subsidiary research question will be discussed in this section. In addition, the discussion will include implications for nursing, strengths and limitations of the study and recommendations for future research.

The first major research question examined the relationship between leadership behaviors and optimism. Analysis indicated no significant relationship between the variables in this sample.

Leadership was not related to the head nurse's level of optimism. This can be explained because optimism is internal and cannot be measured by another individual. Optimism is an intrapersonal trait. Leadership behaviors are observable and measurable by the supervisor.

The second major research question addressed the relationship between leadership behaviors and coping strategies. Analysis revealed no significant relationship between leadership behaviors and confrontive and evasive coping strategies in this sample. Only the confrontive and evasive subscales had acceptable Cronbach Alphas, therefore, this question could not be addressed completely.

Apparently, the use of confrontive and evasive coping strategies does not influence leadership behaviors. Perhaps, head nurses use other strategies in the work environment. It is not surprising that head nurses do not use evasive coping when the questions on the instrument are

considered. "Slept more than usual" or "avoided being with people" are representative questions from the evasive subscale. It is obvious that head nurses can neither sleep or avoid people in the workplace.

However, it is perplexing to contemplate the lack of a relationship between confrontive coping and leadership in this sample of head nurses. Questions in the confrontive subscale include, "tried to work out a compromise" and "set up a plan of action". These are coping strategies that are required for the head nurse position but apparently were not associated with leadership in this sample.

Consideration must be given to the fact that the preferred use of a coping strategy is an internal function and is an intrapersonal trait. Leadership behaviors that were measured by the head nurse's supervisor are external. This may explain why there was no relationship between leadership behaviors and coping.

No other relationships between leadership behaviors, and coping, or leadership behaviors and optimism were found. This suggests that leadership behaviors are not influenced by the use of coping strategies or the level of dispositional optimism.

There was a significant relationship between the JCS confrontive coping subscale and the LOT measure of dispositional optimism. This finding suggests that a higher level of dispositional optimism does act as a facilitator to coping in a problem-focused manner. This is consistent with earlier findings of Scheier and Carver (1985) in which the use of problem-focused coping is an attempt by the individual to do something that will facilitate movement toward the goal with which the stressor is interfering.

The use of confrontive coping is a problem-focused coping method. Head nurses' jobs require successful problem-solving in a constantly

changing environment. Dispositional optimism may act as an enabler to facilitate adaptation to changing stressful situations in the workplace. This implication coincides with the findings of Scheier, Weintraub, and Carver (1986) in which optimism was positively correlated with problem-focused coping and emphasizing positive aspects of the stressful situation. Problem-focused coping allows the head nurse to seek support and to emphasize positive aspects of the stressful situation.

Another significant negative relationship was that of the self subscale of leadership behaviors and years of experience as a head nurse. Yura's concepts of self leadership includes adaptability, self control, self direction, and a sensitivity to the responses of others to self which would not necessarily increase with years of experience as a head nurse. The concepts of self are internal intrapersonal traits. Functioning in a position as a head nurse is an external event outside of "self". Therefore, self was not related to leadership behaviors.

A significant relationship existed between the job relations LB subscale and years of experience as a head nurse. Yura's conceptual framework for job relations defines the leader as a competent practitioner, capable of planning, delegating, and utilizing resources of coworkers in order to complete tasks. Years of experience increases the head nurse's effectiveness in these areas. This relationship is consistent with the findings of Adams (1988) in which years of experience were predictive of leadership effectiveness. As the number of years in a position increases, the head nurse becomes proficient at knowing and performing the requirements of the job and utilizing all resources available. The head nurse is able to improve leadership skills and use the nursing process more effectively as he/she acquire more experience. If the head nurse is able to

effectively utilize the nursing process, supervisors must clearly perceive the head nurse as an effective leader.

Experience in a situation lends itself to learned responses. This is especially true if the head nurse has worked with the same coworkers for a long period of time. This kind of relationship allows the head nurse to become familiar with the subordinates pattern of behavior. Familiarity with patterns of behavior in subordinates provides the head nurse with valuable information about possible responses to change, and strengths and weaknesses in professional skills of subordinates. It also cultivates a relationship-oriented leadership style.

A relationship-oriented style of leadership may facilitate effective leadership behaviors and staff satisfaction. This suggestion is consistent with earlier findings of Peck (1988) in which a relationship leadership style was found to increase staff performance.

There was no significant relationship found between leadership behaviors and age of the head nurse. This investigation of leadership and age may help to answer the question of McCloskey and McCain (1988) as to whether older nurses know their jobs better. The age of the nurse is not necessarily an indication of the number of years of nursing experience. The head nurse with more experience would have to be older. To state this more succinctly, the age of the head nurse would increase with experience. In this study the number of years of experience is the factor related to leadership, not age.

Implications for Nursing

There was no relationship between leadership behaviors and optimism, or leadership behaviors and coping. It is suggested from the findings in this study that effective leadership is possible without the nurse leader possessing high levels of optimism or using confrontive or evasive coping strategies. Conclusions about the use of other coping strategies cannot be made. Although these attributes were not related to leadership in this study, the researcher believes that intrapersonal traits are related to leadership. This belief should act as a springboard for further nursing research to identify attributes that are related to leadership. Perhaps future research should utilize leadership instruments that are completed by the head nurse himself/herself. In following this procedure, the research data would be generated completely from the head nurse. Therefore, greater insight into intrapersonal traits might be attained.

The major implication to emerge from this study is the relationship between number of years as a head nurse and leadership effectiveness. If years of experience as a head nurse are associated with leadership effectiveness, then healthcare institutions need to concentrate their efforts on retention of head nurses. Healthcare institutions need to focus attention on programs to increase job satisfaction of head nurses. If head nurses are satisfied with their jobs, then it is less likely that they will leave the head nurse position or the institution.

Another way to increase years of experience in head nurses is to provide nurses initially entering the role with a comprehensive orientation to the head nurse position. A comprehensive orientation would provide the new head nurse with the opportunity to learn new skills before actually

assuming the head nurse position. This should reduce frustration and ultimately decrease the potential for loss of effective leaders from the workplace.

Those in nursing administration need to provide an atmosphere of support by forming a head nurse support group. A support group would provide new head nurses with an opportunity to: 1) seek advice; 2) obtain emotional support; 3) expand knowledge base; and 4) vent feelings in a supportive environment.

Lastly, healthcare institutions need to provide an atmosphere conducive to professional growth. If an institution can convey that they value their nursing leaders, then job satisfaction and retention should increase. This atmosphere that values nursing leadership should be one that encourages the development of new ideas, expression of ideas, and acquisition of new knowledge.

Nurses themselves must assume responsibility for assisting in creating of an atmosphere conducive to the development of leadership through mentoring. Sullivan and Decker (1985) suggest that the relationship of mentor/protege is one of teacher/apprentice. If this is true then nurses have the opportunity to act as mentors in the workplace. Hein and Nicholson (1986) describe the mentor as being accomplished and experienced and capable of extending that knowledge to the protege in a one-to-one relationship. Nursing itself is the richest resource from which to cultivate future leaders through mentoring.

Another finding of the study was the lack of reliability of the fatalistic, emotive, supportant, self-reliant, palliative, and optimistic coping subscales on the Jalowiec Coping Scale (JCS) in this sample. Although this was a problematic finding in the study, it could provide valuable

information to future researchers investigating nursing populations. Perhaps a new coping instrument should be developed for future research involving nurses if satisfactory revisions cannot be made.

Strengths and Limitations

The study was based on factors which have a great impact on not only head nurses but the nursing profession. There are many theories of leadership but not all of them fit with nursing. One of the strengths of this study was that it utilized the conceptual framework of a well known nursing leader. Therefore, it can be uniquely applied to nursing leadership.

A second strength of the study was the reliability of the Leadership Behaviors instrument. The high Cronbach Alphas on all subscales strengthens its application to nursing.

A major limitation of the study was the small sample size (n = 60). Greater numbers in the sample would have strengthened statistical correlations and perhaps changed the relationships between leadership behaviors, coping, and

Another major limitation of the study was the lack of reliability of optimistic, fatalistic, emotive, palliative, supportant, and self-reliant subscales on the Jalowiec Coping Scale (JCS) in this sample. Because these subscales were unreliable inferences could not be made about the sample in this study.

Another limitation of the study was the inability to totally randomly select the sample. The sample was one of convenience due to the time frame for completion of the project. The period in which data collection

occurred was one of limited time for head nurses during the holiday season when scheduling was problematic. This time limitation for the head nurses may have precluded involvement in the study and influenced the results.

A final limitation was the correlational descriptive nature of the study. No causal relationships could be tested. This limited the application of the findings.

Recommendations

Recommendations from the study include:

1. Further research to investigate relationships of leadership behaviors to coping and optimism using a larger sample size.
2. Additional research to investigate the relationship between the use of specific types of coping strategies and dispositional optimism.
3. Further research to test the relationship of leadership behaviors in other nursing groups.
4. Further research to identify potential leadership behaviors in student nurses during their educational programs.
5. Additional research using a self-reported type of leadership behaviors instrument and a different coping instrument.
6. Longitudinal studies to investigate the impact of higher education on leadership behaviors.

Conclusions

Effective leadership in head nurses is significantly correlated with years of experience as a head nurse. Healthcare institutions need to focus efforts on: 1) the retention of head nurses; 2) professional growth of head nurses through the development of new ideas and expression of ideas; 3) providing a supportive atmosphere for nurse leaders and 4) encouraging nurse mentoring.

In this study there was no relationship between leadership behaviors and optimism, or leadership behaviors and coping. Based on these findings, there is no evidence to support psychological testing for prospective head nurse candidates.

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APPENDIXES

APPENDIX A

INFORMED CONSENT

Certification of Subject Consent

Dear Participant,

Being a head nurse today is a very difficult job. Unfortunately, nobody knows what makes individual people effective as head nurses. As part of my research as a graduate student, I am trying to identify factors which are associated with effective leadership. I would appreciate your helping me learn more about this.

This is a research study that involves completing questionnaires and the duration of participation is limited to completion of questionnaires. Head nurses selected from Knoxville area hospitals are being asked to complete three questionnaires, a demographic data sheet, the Life Orientation Test, and the Jalowiec Coping Scale. The purpose of the study is to see if these factors are correlated with leadership behaviors. Each selected head nurse's immediate supervisor will be asked to complete a standardized assessment of leadership behaviors. The supervisors will not know the head nurses responses to questionnaires and the head nurses will not know the responses of the supervisors. A stamped self addressed envelope will be provided so that the completed packet can be returned to the researcher directly. Completion of the questionnaires will take approximately 45 minutes.

Code numbers will be used and names will not be solicited on the questionnaires. The researcher will be the only individual with access to the code numbers.

There is no anticipated risk or experimentation involved. The benefit of participation is to help provide nurses and health care workers with information about factors which enhance leadership effectiveness. Participation is voluntary and you may withdraw at any time without penalty. There will be no financial payment for your participation in this study.

Research data will be stored in a locked file cabinet in the researcher's home. The Graduate Research Committee will have access to statistical information, but no individual identifying information will be shared with them. Data collection will occur December 1990 through February 1991. I realize your time is at a premium, particularly during the holiday season, but prompt return of completed questionnaires will be greatly appreciated. If you wish to know the findings, please contact me. Thank you.

I have read, understand, and agree to participate:

_____

(Signature)

Melissa Justice R.N.
Graduate School of Nursing
University of Tennessee
Knoxville, Tennessee
(615) 974-4151

APPENDIX B

LEADERSHIP BEHAVIORS INSTRUMENT

Leadership Behaviors

Read Carefully:

A five point numerical scale (4....3....2....1....0) will be used to indicate the rating. The interpretation of the extreme points on the continuum ranges from:

#4 - Outstanding
#0 - Inadequate

Thus the rating:

4.....3.....2.....1.....0
Outstanding <----------> Inadequate

Directions:

1. Read each statement of behavior.
2. Indicate your judgment of the head nurse's performance of each of the behaviors.
3. Place the number which most closely indicates your judgment, i.e., 4 or 3 or 2 or 1 or 0, in the space provided at the end of the statement.
4. Respond to every statement.

Statement of Leadership Behavior	Rating
1. Evaluates own needs	(_____)
2. Demonstrates the ability to grasp ideas fully	(_____)
3. Demonstrates a sensitivity to the ways people communicate with each other	(_____)
4. Can persuade groups to agreement on specific issues	(_____)
5. Can see a job to completion	(_____)
6. Constructively criticizes own performance	(_____)
7. Can assess a complex situation and reduce it to component parts	(_____)

4.....3.....2.....1.....0
Outstanding <----------> Inadequate

8. Demonstrates an awareness of the influence of personal and interpersonal factors on thoughts and actions (_____)

9. Acts as spokesperson for the group (_____)

10. Gets a job done with as little friction as possible (_____)

11. Organizes thought for clear, logical expression (_____)

12. Manifests a mastery of the known body of scientific principles and theories pertaining to nursing (_____)

13. Listens attentively for meaning and for feeling (_____)

14. Supports group members in their actions (_____)

15. Is skillful in getting others to work together effectively (_____)

16. Informs and explains in a clear, orderly fashion (_____)

17. Can predict the consequences of their decisions (_____)

18. Demonstrates a sensitivity to the perceptions of others (_____)

19. Encourages the understanding of points of view of other group members (_____)

20. Plans ahead on what should be done (_____)

21. Can determine the course of action, and move toward a goal without prompting, pressure, and guidance (_____)

22. Can recognize and locate resources necessary to the solution of a problem (_____)

4.....3.....2.....1.....0
Outstanding <----------> Inadequate

24. Influences the group in goal setting and goal achievement (_____)

25. Speaks in manner not to be questioned (_____)

26. Demonstrates an awareness of own strengths and weaknesses (_____)

27. Makes decisions on a factual basis (_____)

28. Behaves effectively in different and changing interpersonal situations. (_____)

29. Directs efforts toward unifying the desires and efforts of group members (_____)

30. Sets an example by working hard themselves (_____)

31. Strives to understand self and others. (_____)

32. Assumes responsibility for action taken based on own decisions (_____)

33. Demonstrates a persuasiveness in dealing with individuals (_____)

34. Does little things to make it pleasant for members of the group (_____)

35. Can supervise a group members job and evaluate it and correct it (_____)

36. Seeks to learn the impact of self on others (_____)

37. Grasps essentials of a problem, sees alternative solutions, and selects appropriate solutions (_____)

38. Holds the attention of others while presenting pertinent ideas (_____)

39. Tries out new ideas on the group (_____)

40. Delegate responsibility appropriately (_____)

4.....3.....2.....1.....0
Outstanding <----------> Inadequate

41. Behaves realistically in face-to-face situations with others (_____)

42. Discriminates between relevant, irrelevant, essential, and accidental data (_____)

43. Gets others to follow their advice and direction (_____)

44. Encourages group members to work as a team (_____)

45. Directs group members or instructs them on what to do (_____)

46. Establishes precedent rather than conform to the immediacy of the situation (_____)

47. Originates new approaches to the problem (_____)

48. Holds to own convictions when he/she feels they are right. (_____)

49. Makes his/her attitude clear to the group (_____)

50. Has group members share in decision making (_____)

51. Demonstrates interest in own self development (_____)

52. Initiates action for new and better procedures and policies (_____)

53. Brings about changes in a persistent, firm manner (_____)

54. Uses discretion, tact, and explanation to get full cooperation from others (_____)

55. Knows exactly what to do and how to proceed (_____)

56. Distinguishes between real and imaginary pressures (_____)

57. Is friendly and approachable (_____)

4.....3.....2.....1.....0
Outstanding <----------> Inadequate

58. Demonstrates a sensitivity to the motives of others (_____)

59. Sees to it that the work of group members is coordinated (_____)

60. Adapts own behavior to meet changing situations (_____)

61. Criticizes a specific act rather than a person (_____)

62. Stands up for the group even if it makes them unpopular (_____)

63. Demonstrates competency as a practitioner in nursing (_____)

64. Can define own role in a situation (_____)

65. Explains the reason for criticism (_____)

66. Encourages group members to express ideas and opinions (_____)

67. Encourages slow working members to greater effort (_____)

68. Gives credit when credit is due (_____)

69. Shows group members how each job fits into the total picture (_____)

70. Follows rules and regulations without question (_____)

APPENDIX C

LIFE ORIENTATION TEST

Life Orientation Test

Please circle your response to the items below. Be as honest and accurate as you can. Do not let your answer to one question influence your answers to other questions. There are no correct or incorrect answers.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1) In uncertain times, I usually expect the best.	0	1	2	3	4
2) It's easy for me to relax	0	1	2	3	4
3) If something can go wrong for me, it will.	0	1	2	3	4
4) I always look on the bright side of things.	0	1	2	3	4
5) I'm always optimistic about my future.	0	1	2	3	4
6) I enjoy my friends a lot.	0	1	2	3	4
7) It's important for me to keep busy.	0	1	2	3	4
8) I hardly ever expect things to go my way.	0	1	2	3	4
9) Things never work out the way I want them to.	0	1	2	3	4
10) I don't get upset easily.	0	1	2	3	4
11) I'm a believer in the idea that "every cloud has a silver lining."	0	1	2	3	4
12) I rarely count on good things happening to me.	0	1	2	3	4

APPENDIX D

DEMOGRAPHIC DATA SHEET

Demographic Data Sheet

Age (years): _____

Sex: F_____ M_____

Marital Status:

Never Married_____

Married, living with spouse_____

Widowed_____

Separated or Divorced_____

Highest Degree

ADN_____

Diploma_____

BSN_____ BA_____ Other_____

MSN_____ MA_____ Other_____

Other_____

Years of Clinical Nursing Experience_____

Years of Experience as Head Nurse_____

APPENDIX E

JALOWIEC COPING SCALE

Jalowiec Coping Scale

For each coping method listed, circle one number to show how often you have used that method to cope with the stress listed.

0 = never used
1 = seldom used
2 = sometimes used
3 = often used

1. Worried about the problem	0	1	2	3
2. Hoped that things would get better	0	1	2	3
3. Ate or smoked more than normal	0	1	2	3
4. Thought out different ways to handle the problem	0	1	2	3
5. Told yourself that things could be much worse	0	1	2	3
6. Exercised or did some physical activity	0	1	2	3
7. Tried to get away from the problem for awhile	0	1	2	3
8. Got mad and let off steam	0	1	2	3
9. Expected the worst that could happen	0	1	2	3
10. Tried to put the problem out of your mind and think of something else	0	1	2	3
11. Talked the problem over with family or friends	0	1	2	3
12. Accepted the situation because very little could be done	0	1	2	3
13. Tried to look at the problem objectively and see all sides	0	1	2	3
14. Daydreamed about a better life	0	1	2	3
15. Talked the problem over with a professional person (such as a doctor, nurse, minister, teacher, counselor)	0	1	2	3

0 = never used
1 = seldom used
2 = sometimes used
3 = often used

16. Tried to keep the situation under control	0	1	2	3
17. Prayed or put trust in God	0	1	2	3
18. Tried to get out of the situation	0	1	2	3
19. Kept your feelings to yourself	0	1	2	3
20. Told yourself that the problem was someone else's fault	0	1	2	3
21. Waited to see what would happen	0	1	2	3
22. Wanted to be alone to think things out	0	1	2	3
23. Resigned yourself to the situation because things looked hopeless	0	1	2	3
24. Took out your tensions on someone else	0	1	2	3
25. Tried to change the situation	0	1	2	3
26. Used relaxation techniques	0	1	2	3
27. Tried to find out about the problem	0	1	2	3
28. Slept more than usual	0	1	2	3
29. Tried to handle things one step at a time	0	1	2	3
30. Tried to keep your life as normal as possible and not let the problem interfere	0	1	2	3
31. Thought about how you had handled other problems in the past	0	1	2	3
32. Told yourself not to worry because everything would work out fine	0	1	2	3

0 = never used
1 = seldom used
2 = sometimes used
3 = often used

33. Tried to work out a compromise	0	1	2	3
34. Took a drink to make yourself feel better	0	1	2	3
35. Let time take care of the problem	0	1	2	3
36. Tried to distract yourself by doing something that you enjoy	0	1	2	3
37. Told yourself you could handle anything no matter how hard	0	1	2	3
38. Set up a plan of action	0	1	2	3
39. Tried to keep a sense of humor	0	1	2	3
40. Put off facing up to the problem	0	1	2	3
41. Tried to keep your feelings under control	0	1	2	3
42. Talked the problem over with someone who had been in a similar situation	0	1	2	3
43. Practiced in your mind what had to be done	0	1	2	3
44. Tried to keep busy	0	1	2	3
45. Learned something new in order to deal with the problem	0	1	2	3
46. Did something impulsive or risky that you would not usually do	0	1	2	3
47. Thought about the good things in your life	0	1	2	3
48. Tried to ignore or avoid the problem	0	1	2	3
49. Compared yourself with other people who were in the same situation	0	1	2	3

0 = never used
1 = seldom used
2 = sometimes used
3 = often used

50. Tried to think positively	0	1	2	3
51. Blamed yourself for getting into such a situation	0	1	2	3
52. Preferred to work things out yourself	0	1	2	3
53. Took medications to reduce tension	0	1	2	3
54. Tried to see the good side of the situation	0	1	2	3
55. Told yourself that this problem was really not that important	0	1	2	3
56. Avoided being with people	0	1	2	3
57. Tried to improve yourself in some way so you could handle the situation better	0	1	2	3
58. Wished that the problem would go away	0	1	2	3
59. Depended on others to help you out	0	1	2	3
60. Told yourself that you were just having some bad luck	0	1	2	3

VITA

Melissa Morris-Justice was born in Jellico, Tennessee on June 3, 1953. She attended elementary school in Campbell County Tennessee and graduated from LaFollette High School in 1970. The following fall she attended St. Mary's School of Nursing and in June, 1973 received her diploma in nursing to practice as a Registered Nurse. She reentered Lincoln Memorial University in August, 1986 and in May, 1989 received her Baccalaureate Degree in Nursing. In August, 1989 she entered The University of Tennessee, Knoxville and in May, 1991 received her Masters Degree in Nursing.

She is presently employed be Jellico Community Hospital in Jellico, Tennessee in the Intensive Care Unit. She resides in LaFollette, Tennessee with her husband, Leon and their two children , Thomas and Heather. Melissa was named to Who's Who in American Nurses for 1990-1991. She is a member of Sigma Theta Tau.