THE ENACTMENT OF A NEW ROLE BY NEW MEMBERS IN ESTABLISHED WORK GROUPS: THE COMMUNITY PSYCHIATRIC NURSES IN BRITISH COLUMBIA

by

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ABSTRACT

This study examines the factors affecting the degree of enactment of a new role by a new member to a small group within a formal organization. The enactment of any role is affected by factors of the social system in which it is performed, for example the norms and the role performance of others; and by characteristics of the individuals performing the role, for example their ability and willingness to perform the role, plus other factors such as the role model or coach who helps the new member learn to perform the role.

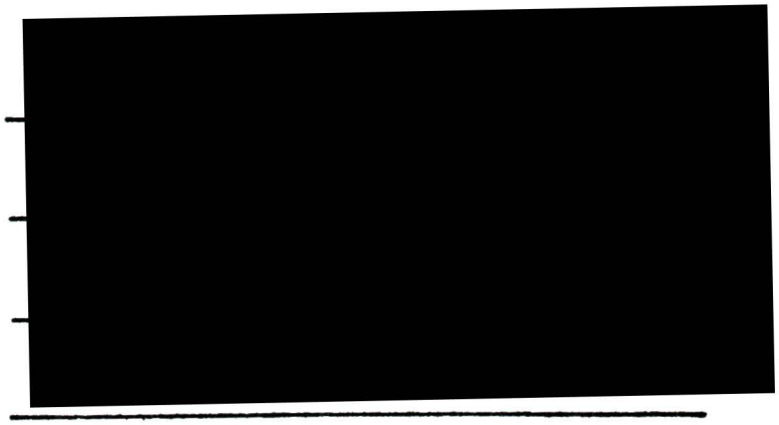
The population was the 18 nurses in the Community Psychiatric Nursing Positions at data collection time plus the 2 nurses who had resigned and who had not been replaced. A contextual field study of the nurses and the staff groups in which they were located was carried out. Data were collected from each nurse and each staff group through structured interviews.

The findings reveal that the role model identified by the new nurse is the most important variable and that the degree of division of labor of the group is the second most important variable affecting role enactment.

That is, nurses who identify a doctor or a nurse as their role model or coach, and nurses who are located in staff groups with a high division of labor, have a high degree of enactment of the new role.

These findings suggest ways that a new role can be successfully introduced into a small group within an organization. In particular, when the role is specialized and to be performed by a new member, if the new member is located in a group which has a high division of labor; and, if the new member's role model is able to enact the new role, then the new member is likely to enact the new role as prescribed.

Examiners:



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Chapter I

INTRODUCTION

Roles are the "major building blocks of all social structure" (Merton 1957:110). This is because "society exists where a number of individuals enter into interaction" (Simmel 1971:23) and because "all living organisms are bound up ... in a complex of social interrelations and interactions ... " (Mead 1967:228). The assignment, learning, and enactment of roles are an integral part of these "interactions" and essential to the existence of groups and societies (Linton 1936:132). The study of roles and how they are enacted, then, is basic to understanding social processes and social structure.

In this study we are interested in a role defined by a formal organization and enacted by a new member located within a small staff group. The role is new, specialized, and has low prestige. The role is new because no other positions in the organization are formally assigned this role. The role is specialized because it is made up of "behaviors differentiated from others" (Biddle et al, 1966:12); that is, this role relative to other roles within the group, is composed of a narrow range of role behaviors. The role is assumed to have

low prestige because the client-recipients of the role behavior are persons from the lower social strata (Clark, 1949:433; Kerr, 1967:159; Vaisanen, 1975:22-33) and because the role is to be enacted in the staff groups by new members who are from a relatively low-prestige occupational grouping (Reiss, 1961:263; Treiman, 1977:45-48). This study, then, examines what factors explain the variability in the degree to which this role, as formally prescribed, is enacted by these members.

Background of the Problem

In 1974 the Ministry of Health assigned new staff to enact a new role. These new staff members, Community Psychiatric Nurses, were expected (by the Ministry) to specialize in services for a particular type of patient in the community, that is persons 18 years of age or older and diagnosed as "psychotic"[1] (ICD-9 codes 295 to 299).[2] The first Community Psychiatric Nurses were nineteen Registered Psychiatric Nurses and one Registered Nurse who were chosen through a rigorous selection process and

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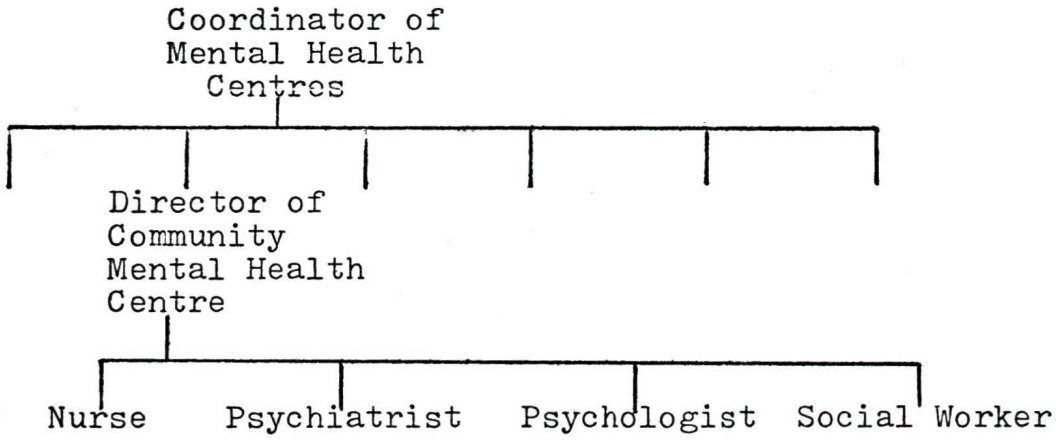
[1] This is from the Public Service Commission job description for the Nurse 2 (the Community Psychiatric Nurse).

[2] The International Classification of Diseases, 9th revision is adapted from the American Psychiatric Association's (1968) D.S.M.2.

then participated in a four month orientation program. (Page and Green, 1975). These nurses who had proven to be both effective and efficient in hospital settings with this type of patient, were also expected to be effective and efficient in a community setting.

Figure I: Partial Organizational Chart of the Ministry of Health: Community Mental Health Programs



The Community Psychiatric Nurses were assigned to twenty new positions located in fourteen community mental health centres throughout the province. These centres vary in size from one to ten staff members and include some combination of professionals from nursing, medicine,

psychology, and social work (Cumming, 1979:43). The mental health professionals provide services for the population residing in the centre's catchment area; these services include counselling, psychotherapy, and chemotherapy, for children and adults[3] of all diagnostic categories (ICD-9 codes 295-319).

The community mental health centres are located at the bottom of the organizational structure (see Figure I). The staff of each centre including the new nurse is responsible to the Director of the centre, who in turn is responsible to the Coordinator of Centres, and so on. The centres are similar to the wards of a state hospital as described by Smith (1965:383): "the locus of organizational initiative is front-line units", "the task of each unit is performed independently of other like units", and "there are obstacles to the direct supervision of the activities of such units." Because of these features Smith said the wards have considerable power over the role definition of members, and because the task performed, care of patients, is a major part of the total organizational activity, then the wards also have considerable power to influence overall hospital policy. Similarly, the centres are very powerful: they have considerable

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[3]See Hedley (1977) for a description of some of the activities of professionals on a similar type of mental health team.

internal authority to define the roles of group members, and they also have considerable external power or influence on policies defining community mental health services in the Province.

After the positions had been assigned to centres, there were some indications that the nurses may not have been specializing in services for adult psychotics as set forth in their role requirements. As early as four months after the original nurses began, Page and Green (1975:27) found that "the nurses are primarily caring for adults, however, several nurses have assumed limited responsibilities for the care of adolescents and children. In addition, some nurses are working with individuals who are not acutely or chronically psychotic, but...are disabled in other ways...". This trend to non-specialization appears to have continued; two years later Stratton (1977) found from a random sample of files closed by these nurses in 1975 and 1976, that 29.3% of the patients had no history of psychiatric care and no closing diagnosis of psychosis. Because most psychotic patients would be expected to have a history of psychiatric care or to be diagnosed psychotic, it is reasonable to assume that one third of these patients were not psychotic. The findings of both these studies suggest that the nurses may be providing services for other kinds of patients and may not be specializing in services for adult psychotics.

If the nurses do not enact this new role, the effectiveness and efficiency of the care that this type

of patient receives may suffer. As the prevalence of adults with psychosis in the general population is about .5% or 1 adult in 200[4], this is important. Failure of these nurses to specialize in services for psychotic adults in the community may mean that: (1) patients use less efficient services such as hospitals or more expensive community professionals than the nurse; or, (2) patients have less effective or no services available to them in the community. Since psychotic adults usually require years of supervision or rehabilitation, the availability in the community of effective and efficient services is important to the patient, his family, and the community. The question then becomes: under what conditions will the nurse enact the role as formally prescribed?

From a sociological perspective this concrete problem becomes one of understanding new members, new roles, and role enactment. The problem is that when new members are introduced into established groups to enact a new role, there is variability in the enactment of this role. The question then becomes: what factors explain the variability in the enactment of a new role by a new member in a small group?

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[4]This is the rate quoted from Dr. J. Cumming's verbal statement in June, 1979. In addition, Brunetti et al (1975) in France report psychosis rates of 1.58% to .8%; and, Vaisanen (1975) in Finland reports psychosis rates of 1.9%. Therefore, .5% appears to be a very conservative estimate.

Theoretical Background

Role enactment or role performance or role behavior is defined in the literature in a number of different ways. Role enactment is the set of behaviors the role occupant actually carries out (Shaw, 1971:244) or the overt performances of persons (Sarbin, 1954:229, R. Turner, 1956:316) or "practically all social acts" (Goslin, 1969:6). J. Turner (1978:354) in his review of "Role Theory" emphasised that concept priority is given to overt behavior for role enactment. Role enactment in this study is the patterns of behavior of the occupant of a particular status or position.

Role enactment is different from the role per se. Neiman (1951:145) in a survey of the literature on roles from 1910 to 1950, concluded that the concept role is "vague and nebulous on the whole"; however, he said the concept role is most frequently used in "association with the concept status". According to R. Turner (1956:316) a role is a "collection of patterns of behaviors which are thought to constitute a meaningful unit and deemed appropriate for a person occupying a particular status in society." Goslin (1969:6), summing up Merton, Gross, and Biddle, said a role is "behavior legitimately expected of the occupant of a position." A role, then, is the expected patterns of behavior of the occupant of a

status or position.

The enactment of any role associated with any position is affected by factors of the social system in which the role is enacted and by characteristics of the individual enacting the role. Factors of the social system include (1) the social norms regarding the role (Biddle and Thomas, 1966:4), and (2) the role performance of others (Biddle and Thomas, 1966:4; Goode, 1960:249). Factors of the individual enacting the role which may affect the enactment of a role include (1) the individual's ability to enact the role (Biddle and Thomas, 1966; Reisman, 1949:306), (2) the individual's "desires" (Brim, 1966:25) or values or willingness to enact the role, and (3) the individual's experiences in enacting the role (Sarbin, 1954:226). Because individuals are "socialized...to...role behavior" (Goode, 1960:249) the individual's experiences when he is learning a role are particularly important.

The factors affecting role enactment in a small staff group within a formal organization are similar to the above. The major social systems affecting the enactment of a role are the organization and the membership or staff group in which the individual enacting the role is located. Factors of the first social system, the organization, are constant because there is one formal definition of the role (formal norms), and the same organizational

structure exists for all members in the organization. The social systems of membership, the staff groups, may vary and affect the enactment of roles within the group. Furthermore, the individuals enacting roles within an organization each can be expected to vary on some or all the factors mentioned previously.

The variability among staff groups is important to consider in the enactment of a role within an organization. First, the staff groups are important because individuals are most affected by the groups in which they participate (Shibutani, 1955:565) and they usually would participate in the staff groups. Second, the staff groups are important because the most important determinants of behavior are the "manifest subcultural values" which grow around specific roles in a designated setting (Becker and Carper, 1956:341), or the informal norms that develop in the staff groups. Third, the staff groups are important because new group members are likely to be "anxious and conformity prone" (Nash and Heiss, 1967; Nash and Wolfe, 1957) and these members are new to the groups. Finally, the staff groups in this study are important because of their potential power over role definition as discussed above. (see page 5).

The staff groups are, also, particularly important to consider in this study because the role to be enacted is new and nonemergent. The role is nonemergent because

it did not originate within the group but is assigned by the organization.[5] Torrance (1954:135) while studying emergent roles found that small permanent groups (B-26 combat crews), compared to small temporary groups, tend to maintain their role structure and not develop new roles. Burke (1967), Fisek & Ofshe (1970), and Slater (1955) found new roles emerge in the early phases of a group; but no studies other than Torrance's were found which examine emergent or non-emergent new roles per se in established small groups. It appears, then, that new roles may be relatively difficult to introduce into established groups.

The addition of new members or new roles to formal organizations has been discussed by a number of authors. For example, Mustafa et al (1978) in a study of 14 middle managers found that the managers trained in "laboratory groups" to perform new behaviors were not performing these behaviors at all three months later. In this study old members fail to enact a new role in the organization although they have been trained for it. Saleh (1973) provided a general description of the role of the psychologist in organizations; plus he made suggestions to help psychologists fit into organizations. Saleh

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[5]See Burke (1967:379-392) for a description of emergent roles.

appears to be describing a new member who is a marginal man within the organization and who is having difficulty enacting a new role. Van Horne (1976) described his experiences in the role of sociologist within an organization. He found that the role was tightly and narrowly defined by the organization and the staff groups - he left the organization after 3 months. This paper shows what can happen to a new member in a new role if the role prescription is rigid. Finally, Izraeli (1979) described how a new member establishes a new management role within a small organization through coalition formation and role enterprise. This last paper is an excellent example of the successful enactment of a new role by a new member. Overall, though, it appears the addition of new members and new roles to organizations may present special problems.

A closer look at the above studies reveals that very little quantitative information is available. Two of these studies (Saleh and Van Horne), are presented from the point of view of the new member. Some of the group and individual factors are described, but no measurement of the degree of enactment of the role (as defined by the organization or the new member) is attempted. The other two studies are presented from a third person perspective. Izraeli's study is a description and theoretical analysis of the "Settling In" process of a

new manager. Mustafa's paper, on the other hand, presents quantitative measures of role enactment, but does not examine either individual or group factors. This present study, then, tries to do both these things; that is, quantitatively measure the degree of enactment of a new role by a new member (as defined by the organization), and examine the group and individual factors affecting the degree of role enactment.

Theoretical Hypotheses

Group Level Hypotheses

A number of variables of the membership groups may affect the enactment of the role. First, the norms or "ideas in the minds of the members of a group" (Homans, 1950:122), about the role are important. Because we know group members are influenced by the group (Asch, 1951; Sherif, 1935; Deutsch, 1955) and a new member is likely to be particularly susceptible to the group (Nash & Heiss, 1967), the norms about the new role that exist and develop in this group will affect the enactment of the new role. It is hypothesized that (1) the strength of norms accepting the new role will be positively related to the degree of enactment of the new role by the new member.

Second, the role performance of others affects the

enactment of a role. The roles being enacted in the membership groups include those pertaining to the horizontal differentiation of the group (the division of labor), the vertical differentiation of the group (the stratification), and the types of occupations represented. Because of the unusual combination of professionals from different occupational backgrounds this latter variable should have effects independent of division of labor and stratification. The preceding group level variables are part of the existing group structure; that is, they are present before the arrival of the new member and the new role; and therefore, are present before norms regarding the new role and before the enactment of the new role.

The degree of division of labor of the group is an important independent variable because the new role is specialized; therefore it should integrate both behaviorally and normatively into a group with other specialized roles. Durkheim (1974:430-434) pointed out that division of labor develops when the group is ready for it, not by imposing specialization from outside the group. Therefore, (2) the degree of division of labor of the group will be positively related to strength of group norms accepting the new role, and (3) positively related to the enactment of the new role by the new member.

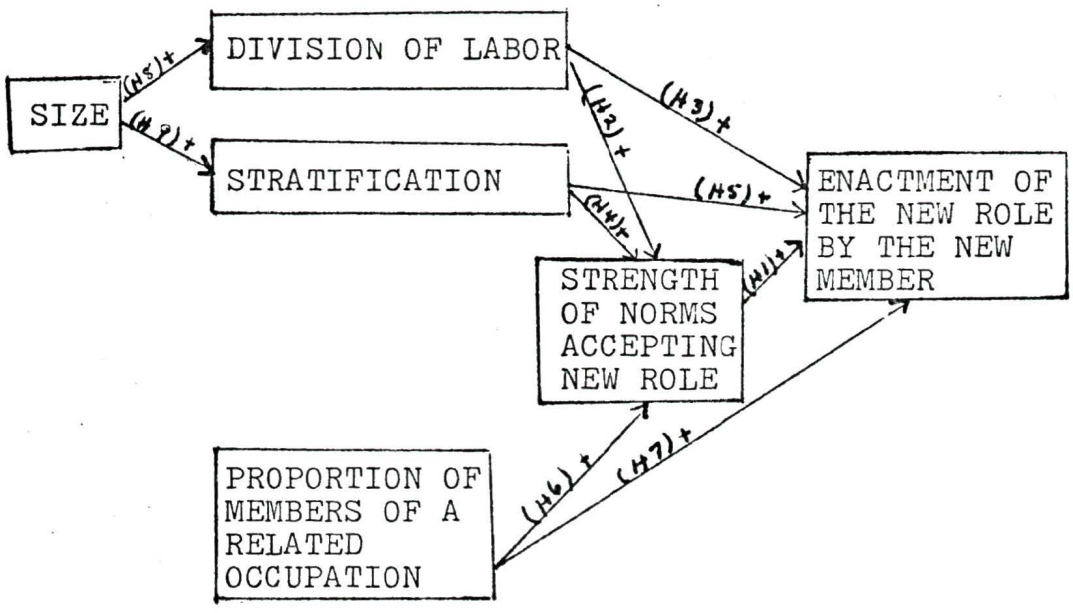
Stratification, another independent variable, is the ranking of persons in a hierarchical system (Benoit, 1944:151; Biddle et al, 1966:66; Blalock, 1975:358; Hyman, 1942:47; Kornhauser, 1953:224). In this study occupational prestige provides a status structure because the occupations of members of the staff groups have different prestige ratings in the greater society (Treiman, 1977; NORC, 1953), and this stratification should carry over in the groups (Berger et al, 1973:198; Strodtbeck et al, 1957:719). The new members to the group belong to an occupational type (nurse) that has relatively lower occupational prestige in general society than the prestige of the other occupations such as psychologist, psychiatrist, and social worker (Treiman, 1977:240). A highly stratified group (occupational prestige) probably has a stratification of working roles congruent with the stratification structure; therefore both behaviorally and normatively a low prestige role enacted by a relatively low (occupational) prestige new member would be added with little disturbance to the existing status structure. Therefore, it is likely that (4) the degree of stratification of the group will be positively related to the strength of group norms accepting the new role and (5) positively related to the degree of enactment of the new role by the new member.

The composition of occupational types in the groups is also an important independent variable. Members of related occupations who are capable of enacting this new role because of their professional training and who frequently and traditionally enact cooperative roles with representatives of the new member's occupation, are more likely at both a normative and behavioral level to be accepting of the new member and the new role. It is hypothesized that (6) the proportion of members with an occupation related to the new member's occupation will be positively related to the strength of norms accepting the new role and (7) positively related to the degree of enactment of the new role by the new member.

Third, the size of the group is another important independent variable because of its effects on the other structural aspects of the group. Kasarda (1974:19) in his analysis of "The Structural Implications of Social System Size" reviewed the contributions of a number of theorists: for example, Spencer in 1877 inferred that structural change inevitably follows from increase in size; Simmel in 1902 said that the size of any group determines its internal structure; Durkheim in 1933 posited that dynamic density is largely predicted on physical density; and Parsons in 1937 said structural change is attributed to a society's increase in members.

In regard to organizations, Meyer (1972:437) pointed out that the "effects of size are ubiquitous". Finally, Hall (1977:108) after reviewing several studies concluded that increased size is related to "increased structuring" in organizations. Therefore, it is hypothesized that (8) the size of the group will be positively related to the degree of division of labor of the group and (9) positively related to the degree of stratification of the group, and through these structural variables to the degree of enactment of the new role by the new member.

Figure II: Diagram of Group Level Hypotheses 1 to 9



Individual Level Hypotheses

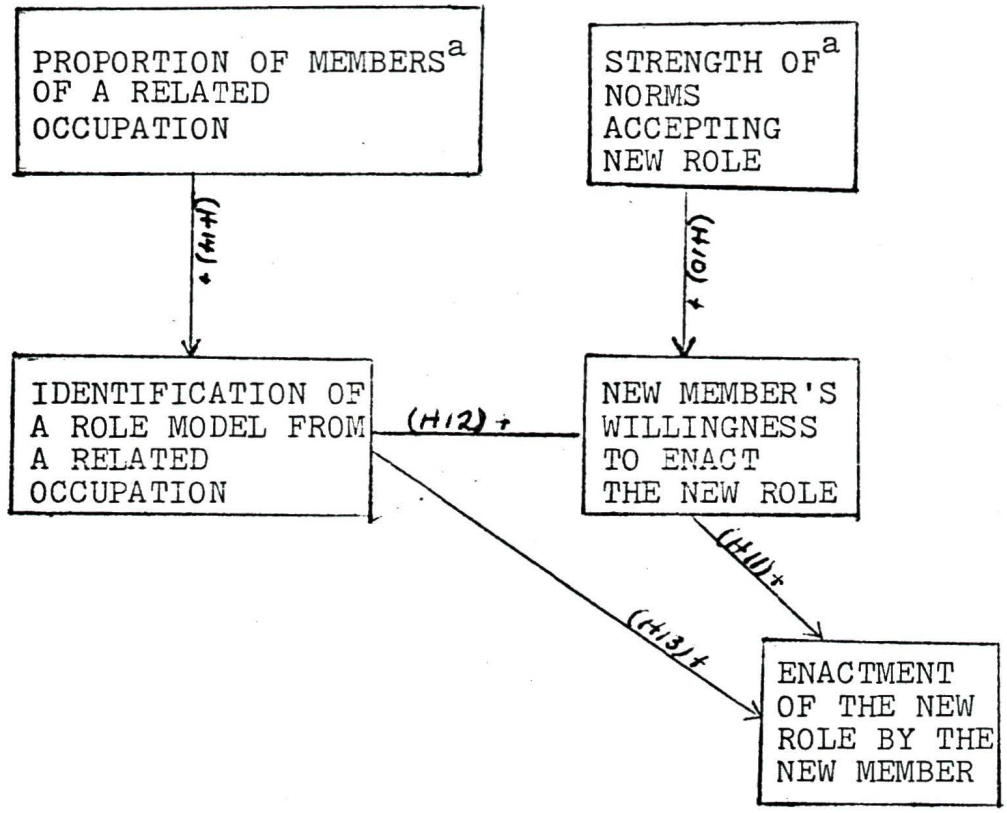
The enactment of any role is affected by characteristics of the individual role holder. First, the individual's ability to enact the role is important. However, it is not examined in this study because the new members (nurses) have almost identical educational and occupational backgrounds and, therefore, have very similar ability to enact the new role. Second, a characteristic which may vary is the new member's willingness to enact the new role. At least some willingness must have been present before role enactment because the new member applied for the position and knew what the role was. As the individual becomes a member of the group, however, his degree of willingness to enact the new role will be affected by group level variables such as norms, because "social norms and individual desires...have the same direction" (Goode, 1960:247). It is hypothesized, therefore, that (10) the strength of norms accepting the new role will be positively related to the degree of willingness of the new member to enact the new role and that (11) the degree of the new member's willingness to enact the role will be positively related to the degree of enactment of the new role by the new member.

A third factor that may affect the enactment of the role is the experience the new member has in enacting the new role. Individuals learn new roles

through incidental learning (Sarbin, 1954:227), for example imitating a role model (Goode, 1966:313; Sarbin, 1954:226) or a "significant other" (Moore, 1969:876); or, through intentional instruction (Sarbin, 1954:227) by a "coach" (Van Maanen, 1976:92). The role models or coaches who help these new members learn their new roles will affect the enactment of that role. Those most likely to have an appropriate behavior repertoire, that is, skills and knowledge regarding the new role, are members of related occupations. It is hypothesized, therefore, that (12) the identification by the new member of a member of a related occupation as a role model or coach will increase the member's willingness to enact the new role, and (13) increase the enactment of the new role by the new member. In addition, (14) it is likely that as the proportion of related occupations in the group increases, the identification by the new member of a role model from a related occupation will occur.

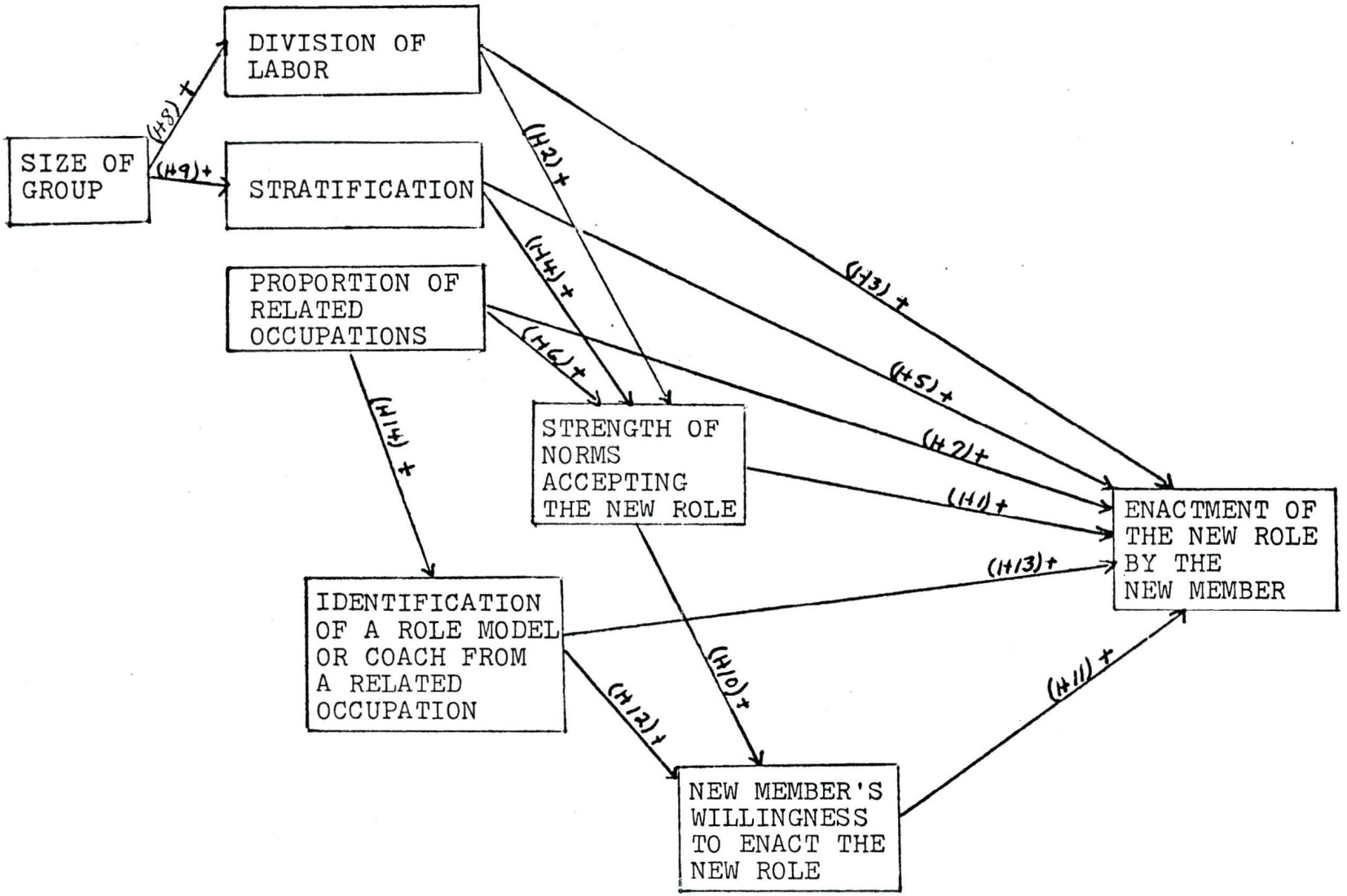
Finally, the effects of the new member's background and socio-demographic characteristics of age, sex, relative status, and length of time in the position will be explored.

Figure III: Diagram of Individual Level Hypotheses 10 - 14



[a]These are group level variables which affect individual level variables.

Figure IV: Summary Model of All Theoretical Hypotheses



Chapter II

METHOD

Research Design

This was a contextual field study (Babbie, 1973:67) which examined characteristics of both the nurse and of the group in which the nurse was located. In order to collect data on both the nurse and the group, a cross-sectional survey was carried out. Structured interviews were conducted first with the staff groups including the nurse, and then with the nurse alone.

Population

The population was the eighteen nurses in the Community Psychiatric Nurse Positions at the time of the study and the two nurses who had resigned and who had not been replaced. The nurses in these positions at data collection time were studied no matter how long they had been in their positions because the enactment of the new role not the nurse *per se*, was the focus of study. As well, all staff groups were studied including those in which nurses had resigned and had not been replaced because the effect of the group on the enactment of the new role was important. In these latter groups the degree of enactment of the new role

by the nurse was considered to be zero.

Research Hypotheses

In order to test the theoretical hypotheses the following research hypotheses were developed.

Group Level Hypotheses

1. The degree of the group's acceptance of the new role, the care of adult psychotic patients, will be positively related to the proportion of the nurse's time spent with psychotic patients.

2. The degree of division of labor of the group will be positively related to the group's acceptance of the new role, care of adult psychotic patients,

3. and positively related to the proportion of the nurse's time spent with adult psychotic patients.

4. The degree of stratification of the group will be positively related to the degree of the group's acceptance of the care of adult psychotic patients,

5. and positively related to the proportion of the nurse's time spent with adult psychotic patients.

6. The proportion of nurses and doctors in the group will be positively related to the group's acceptance of the care of adult psychotic patients,

7. and positively related to the proportion of the nurse's time spent with adult psychotic patients.

8. The size of the group will be positively related to the degree of division of labor of the group,

9. and positively related to the degree of stratification of the group.

Individual Level Hypotheses

10. The degree of the group's acceptance of the new role, care of adult psychotic patients, will be positively related to the degree of willingness of the nurse to spend time with adult psychotic patients.

11. The degree of the nurse's willingness to enact this role will be positively related to the proportion of the nurse's time spent with adult psychotic patients.

12. The identification by the nurse of a nurse or a doctor as a role model or coach will increase the nurse's willingness to spend time with adult psychotic patients,

13. and increase the proportion of the nurse's time spent with adult psychotic patients.

14. As the proportion of doctors and nurses in the group increases, the identification by the nurse of a doctor or a nurse as a role model or coach will occur.

Data Collection

Data were collected between February 15 and March 31, 1979. The sources of data were: (1) the updated staff lists for each group to calculate the size of the group, the proportion of doctors and nurses in the group, and the stratification of the group; (2) the service logs for each group member (Figure V) to complete the division of labor instrument (Figure VI) and to calculate the degree of role enactment; (3) the group's interview schedule (Appendix D) to determine the group's acceptance of the new role; and, (4) the nurse's interview schedule (Appendix C) to determine the nurse's willingness, role model, age, sex, and length of time in the position.

The service logs were a very important source of data. The service log was a standard form completed by each staff member except clerical staff, so that,

Figure V: Sample of a Mental Health Centre Staff Service Log

STAFF MEMBER NAME	UNIT	STAFF CODE	WEEK ENDING	PAGE
C.P.Nurse	00	000	00 00	0 of 0

NAME OF CLIENT OR AGENCY	CLIENT'S FILE NUMBER OR AGENCY CODE	SEX		AGE		DATE		SERVICE GIVEN				NO: OF HALF HOURS	
		M	F	Ad.	Ch.	Day	Mo.	REHAB. THERAPY COUNSEL. Ind.	Fam.	Gr.	ASSESS & DIAG-NOSE		
J. Smith	99999999999	0	✓	✓	0	09	05	✓	0	0	0	0	3
K. Jones	99999999999	✓	0	0	✓	09	05	0	0	0	✓	0	2

each half hour of each working week was accounted for in designated categories (see Figure V).

The group schedule (see Appendix D) plus the division of labor instrument were administered to all groups. The researcher administered them to 11 staff groups which included a pretest group without a nurse. The directors of the other four staff groups completed the group schedule and administered the division of labor instrument. The researcher did not collect the group data in these last four staff groups because of travel restrictions or difficulty in connecting with scheduled staff meetings.

Each Community Psychiatric Nurse was interviewed individually except for the two who had resigned. Seventeen were interviewed at their mental health centres and one was interviewed on the phone. Each interview lasted approximately one hour and was structured by the interview schedule in Appendix C. This schedule was pretested with a nurse who was not a Community Psychiatric Nurse but who was familiar with the formal role. The two nurses who had resigned and who had not been replaced were not interviewed because they could not be traced. The data for these nurses were obtained as follows: their age, sex, and length of time in the position were elicited from other centre staff; and the role model for one nurse was identified because there was only non-nursing and non-medical staff

in that centre; but it was not possible to determine either nurses' willingness to enact the new role.

Measurement

The Dependent Variable

The formal norms regarding this new role were that the nurse was to spend all (100%) of his working time looking after psychotic adults. The degree of role enactment, then, was the proportion of time the nurse actually spent looking after psychotic adults.

The proportion of the nurses' time with adult psychotic patients was calculated from each nurse's service logs ending February 9 and 16, 1979. These particular weeks were selected because they were the last two weeks for which service logs were completed before the interview period began. Thus, all data collected from these logs were for the same time period and were immediately preceding the interviews. These data were collected for a two week period to allow for unusual occurrences such as sickness or holidays. The log categories of "Rehab.", "Therapy", "Counsel", and "Assessment and Diagnosis" were used because these are the categories that account for face-to-face time with patients and, thus, provide the strongest evidence that an actual service for a patient had occurred.

In the presence of the researcher and from the specified logs, each nurse added up the number of half hours he had spent with adult psychotic patients. These patients were 18 years or older and were diagnosed by a psychiatrist or the Community Psychiatric Nurse as either schizophrenic or as having one of the other psychoses (ICD-9 codes 295-299). When patients were involved in group therapy, each half hour of group time was included if the majority of patients were adult and diagnosed as psychotic, or if the main reason for the group meeting was because of a psychotic adult. The number calculated in this manner became the numerator of a fraction. The denominator was the number of half hours spent with all patients for the same time period and for the same service categories. The ratio expressed by this fraction was the proportion of the nurse's "face-to-face" time spent with adults diagnosed as psychotic.

Group Level Independent Variables

The strength of group norms or the degree of group acceptance of the new role was measured by a question to the staff groups:

"If a Community Psychiatric Nurse were to care for only acute and chronic psychotic adults, how many Community Psychiatric Nurses (in total) would be needed to handle this type of patient for your centre?
0 1 2 3 4 ...".

The number agreed on by the staff group was divided by

the total number of staff members involved in patient care in the centre. This, then, provided us with a measure of group acceptance.

The degree of division of labor of each group was measured using Baker's (1979) standardized measure of task specialization. This formula was

$$ST = \sum_{j=1}^{K} \left(S_j * \sum_{i=1}^{N} X_{ij} \right) \Big/ \sum_{j=1}^{K} \sum_{i=1}^{N} X_{ij}$$

where X_{ij} is the number of units (half hours) spent on task j by person i. As well:

$$S_j = \frac{\left[\sum_{i=1}^{N} |X_i - \bar{X}| / N \right] / \bar{X}}{2[1 - (1/N)]} .$$

Data for the number of units (half hours) spent by each professional on each task were collected during the group interview using the instrument in Figure VI. This instrument was prepared based on the researcher's knowledge of and 8 years experience in community mental health centres. In the presence of the researcher (in all but a few cases) each staff member calculated from their service log the amount of time they spent on each task. With these data and Baker's 'ST' formula an index number representing the degree of division of labor was calculated for each centre.

Figure VI: Instrument Used to Measure the Degree of Division of Labor in the Group.

Centre _____ Discipline _____

Please consult your weekly log for the number of Half Hours you spend in a typical working week on each of the following. (This list is not meant to account for every half hour of the week, so please don't attempt to make it balance.)

_____ Administrative functions for the Centre as a whole (exclude staff meetings).

_____ Intake assessments for the Centre as a whole.

_____ Psychological testing for adults.

_____ Prescribing and/or administering and/or monitoring psychotropic medications for adults (exclude Boarding Home Program).

_____ Rehabilitating, resocializing, and/or maintaining adults who have had a psychotic episode in the past but are now in the community (not Boarding Home Program).

_____ Family or group therapy for patients/clients who have never had a psychotic episode.

_____ Assessing, treating, and/or discussing mental health Boarding Home patients.

_____ Preparing prescriptions.

_____ Therapy with individual adults (non-psychotic).

The degree of stratification of each group was based on occupational prestige. Reiss (1961:244) suggested that the prerequisites of an occupation are one of the dimensions determining occupational prestige. Cullen and Novick (1979) found that the length of training has a major effect on occupational prestige. In this study the number of years of post-secondary schooling were used as a measure of occupational prestige. Years were assigned as follows: 10 for a psychiatrist, 7 for a psychologist, 7 for a M.Sc.Nurse, 5 for a social worker, 5 for a B.Sc.Nurse, 3 for a Registered or Registered Psychiatric Nurse, and 1 for a case aide. For each staff group the mean number of years education and then the standard deviation was calculated. This latter parameter provided an index number of the variability, that is, stratification for each group.

The members of a related occupation or the proportion of nurses and doctors was the number of nurses and doctors divided by the size of the group. Nurses and doctors were counted because they are capable of looking after adult psychotics, particularly the administration and monitoring of psychotropic medications and the care of these patients when they are hospitalized. Nurses and doctors also traditionally work together to provide health care services. Members of other occupations (in the centres) are not

specifically trained in these areas nor do they traditionally work with nurses.

The size of each staff group was measured by counting the number of persons employed at each centre in February 1979 from an updated staff list. Each staff member giving patient services was included. Part-time staff were given equal weight to full-time staff because each is a professional using his total professional knowledge base when he is at the centre. In addition, these part-timers are included for staff meetings which are usually the only time these groups meet as a whole. The part-timers then, are important group members.

Individual Level Independent Variables

The degree of the nurse's willingness to enact the new role or to spend time with adult psychotic patients was measured by a question to the nurse:

> "If all your direct service time was to be spent with psychotic adults - acute or chronic - how long do you think you would stay in this job? Not at all... minutes...weeks...months...years."

The possible responses were weighted as follows: minutes (0), weeks (1), months (4), and years (48).

The nurse's role model or coach was measured by the following question:

> "When you first started at this centre, who helped you learn the skills and knowledge you needed to do this job?"

If the nurse answered this by naming a nurse or a doctor then '1' was coded. If any other professional such as a social worker or psychologist was named, then '0' was coded.

Other variables were measured in the following manner. The age in years of each nurse was noted. The sex of each nurse was coded with '0' for males and '1' for females. The nurse's length of time in the CPN position in years was noted.

Data Analysis

Regression analyses were performed to test the hypotheses. Any beta (or Pearson's r in bivariate relationships because beta equals r when only x and y are involved: Kerlinger, 1973:25; Nie et al, 1975:325) of at least 0.10 in the predicted direction was accepted as supporting the hypothesis in this population. This beta was relatively low; but because this was a population, any tendency to support a hypothesis was important. In addition, statistics for sample data which were not really applicable, for example significance levels and adjusted R^2s, were reported for optional evaluation[6]. Simple regressions were examined first, then, multiple regressions to determine if the hypothesis continued to be supported when other independent variables affecting the dependent variables were held constant.

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[6]The R^2c or adjusted R^2 corrects for bias in R resulting from the tailoring of the regression equation to sample data. This correction is important for small samples and where there are a large number of independent variables. The formula shown by Loether and McTavish (1974:319) is $R^2c = 1 - \left(\frac{N-1}{N-k}\right)\left(1 - R^2\right)$ where R^2 = uncorrected coefficient, N = sample size and k = number of independent variables.

Chapter III

FINDINGS

The data are analysed in terms of bivariate and, then, multivariate relationships. All bivariate relationships are shown in Table 1. The multivariate relationships are examined in three parts: first, all variables affecting the group's acceptance of the new role (GRPACTR) are in Table 2; second, all variables affecting the nurse's willingness to spend time with adult psychotic patients (MAINTROL) are in Tables 3 and 4; and third, all variables affecting the proportion of the nurse's time spent with adult psychotic patients (ENACTROL) are in Tables 5, 6, 7, and 8.

Bivariate Analyses

Table 1 presents betas or Pearson's r for hypotheses 1 to 14. The r_s (betas) are low for hypotheses 1 (0.12), 2(0.10), 4(0.20), 7(0.22), 11(0.26), 12(0.16), and 14(0.15). Although each r (beta) is at least 0.10 and therefore meets the substantive criterion for acceptance, the r^2 (explained variance) is very low (<10%) in each case. Thus, the support for these hypotheses is slim. Moderate positive r_s (betas) of 0.41 and 0.42 occur for hypotheses 9 and 10; substantial positive r_s (betas) of 0.69 and 0.57 occur for hypotheses 3 and 5;

and, strong positive r_s (betas) of 0.74, 0.75 and 0.88 appear for hypotheses 6, 8, and 13. Overall, for the bivariate relationships, all hypotheses are supported.

TABLE 1

Simple Regression Analyses for Hypotheses 1 to 14[a]

Independent Variable	Dependent Variable[b]	N	r(beta)	r^2	H[c]	Support
GRPACTR	ENACTROL	20	0.12	0.01	1	Yes
GRPDOL	ENACTROL	20	0.69***	0.48	3	Yes
OBJSTRAT	ENACTROL	20	0.57*	0.04	5	Yes
GRPCOMPR	ENACTROL	20	0.22	0.05	7	Yes
MAINTROL	ENACTROL	18	0.26	0.07	11	Yes
ROLMODEL	ENACTROL	19	0.88***	0.77	13	Yes
GRPDOL	GRPACTR	14[d]	0.10	0.01	2	Yes
OBJSTRAT	GRPACTR	14[d]	0.20	0.04	4	Yes
GRPCOMPR	GRPACTR	14[d]	0.74***	0.55	6	Yes
GRPSIZE	GRPDOL	14[d]	0.75***	0.56	8	Yes
GRPSIZE	OBJSTRAT	14[d]	0.41	0.14	9	Yes
GRPACTR	MAINTROL[e]	18	0.42*	0.18	10	Yes
ROLMODEL[f]	MAINTROL	18	0.16	0.03	12	Yes
GRPCOMPR	ROLMODEL	19	0.15	0.02	14	Yes

* $p < .05$ (one-tailed)
*** $p < .001$ (one-tailed)

TABLE 1 (continued)

[a]Variables:

ENACTROL = the proportion of the nurse's time spent with adult psychotic patients.
GRPACTR = the degree of group's acceptance of the new role.
GRPCOMPR = the proportion of nurses and doctors in the group.
GRPDOL = the degree of division of labor of the group.
GRPSIZE = the number of members in the group.
OBJSTRAT = the degree of stratification (occupational prestige) of the group.
MAINTROL = the degree of willingness of the nurse to spend time with adult psychotic patients.
ROLMODEL = the nurse's role model or coach.

[b]See Appendix F for frequency distribution for each variable.

[c]H = hypothesis

[d]Duplicate centres i.e., those with more than one nurse have been removed from correlations where only structural level variables are involved.

[e]The MAINTROL measure is essentially an ordinal scale which is treated as if it is an interval measure. Support for this approach can be seen in Labovitz (1967, 1970).

[f]ROLMODEL here is a dichotomous variable. It is 'dummy' coded, so that, the identification of a nurse or doctor as a role model or coach equals '1' and any other role model is '0'.

Multivariate Analyses

Table 2 displays the multiple regression analysis for hypotheses 2, 4, and 6. A substantial 59% of the variation in the group's acceptance of the new role (GRPACTR) is explained by the linear and additive effects of the division

of labor (GRPDOL), the stratification (OBJSTRAT), and the proportion of doctors and nurses (GRPCOMPR). The betas for each of these independent variables is the partial effect of each independent variable on GRPACTR, holding the others constant. The betas are negligible (-0.04) for hypothesis 4 (OBJSTRAT), low (0.13) for hypothesis 2 (GRPDOL), and strong (0.77) for hypothesis 6 (GRPCOMPR). Employing this more sophisticated analysis hypothesis 6 is strongly supported, and hypothesis 2 is marginally supported, but support for hypothesis 4 must be withdrawn. The prior support for hypothesis 4 is a function of the combined effects of GRPDOL, GRPCOMPR, and OBJSTRAT.

TABLE 2

Simple and Multiple Regression Analyses for Hypotheses 2, 4, and 6[a]

Independent Variable	Dependent Variable	r[b]	r^2	Beta[c]	H	Support
GRPDOL	GRPACTR	0.10	0.01	0.13	2	Yes
OBJSTRAT	GRPACTR	0.20	0.04	-0.04	4	No
GRPCOMPR	GRPACTR	0.74***	0.55	0.77**	6	Yes

R^2 = .59**
(R^2c = 0.51)
** p<.01
*** p<.001

[a]N = 14 because duplicate centres are removed for structural level variables.

[b]Bivariate analysis

[c]Multivariate analysis

TABLE 3

Simple and Multiple Regression Analyses
for Hypotheses 10 and 12

Independent Variable	Dependent Variable	r^a	r^2	Beta[b]	H	Support
GRPACTR	MAINTROL	0.40*	0.18	0.42	10	Yes
ROLMODEL[c]	MAINTROL	0.16	0.03	0.15	12	Yes

$R^2 = 0.20$
($R^2c = 0.09$)
*$p < .05$
[a]Bivariate analysis
[b]Multivariate analysis
[c]ROLMODEL is dummy coded so that the identification by the nurse of a doctor or nurse as a role model or coach is coded '1' and any other professional is coded '0'.

Table 3 shows the multiple regression analysis for hypotheses 10 and 12. The two independent variables, the degree of the group's acceptance of the new role (GRPACTR) and the nurse's role model (ROLMODEL), affecting the willingness of the nurse to spend time with adult psychotic patients (MAINTROL) maintain the direction and strength of their zero order relationships when the other is controlled through multiple regression analysis. However, GRPACTR has a much greater impact than ROLMODEL; a beta of 0.42 versus a beta of 0.15. In total these two independent variables explain 20% of the variance in MAINTROL. Therefore, although both hypotheses 10 and 12 are supported, 80% of the variation in MAINTROL is left unexplained.

TABLE 4

Simple and Multiple Regression Analyses for Hypotheses 10, 12 and Background and Sociodemographic Variables.[a]

Inde-pendent Variable	Depend-ent Variable	r^b	r^2	Beta[c]	H	Support
ROLMODEL[d]	MAINTROL	0.16	0.03	0.07	12	No
GRPACTR	MAINTROL	0.42*	0.18	0.38	10	Yes
CPNAGE	MAINTROL	0.20	0.04	0.16		
CPNSEX[e]	MAINTROL	-0.04	0.00	-0.08		
CPNLENJB	MAINTROL	-0.42	0.18	-0.38		

$R^2 = 0.37$
($R^2c = 0.10$)
*$p < .05$

[a]Variables:
CPNAGE = the age in years of the nurse.
CPNSEX = the sex of the nurse.
CPNLENJB = the length of time in years that the nurse has been in the CPN position.

[b]Bivariate analysis

[c]Multivariate analysis

[d]ROLMODEL is dummy coded; so that a doctor or a nurse = '1' and any other = '0'.

[e]CPNSEX is dummy coded; so that female = '1' and any other = '0'.

In order to determine if more of the variation in MAINTROL can be explained, background and socio-demographic variables are included in the multiple regression analysis. Table 4 displays these relationships. The linear and additive effects of all these variables explain a moderate 37% of the variation in MAINTROL.

This is somewhat better than the previous 20% (Table 3). The betas are negligible (0.07) for hypothesis 12 (ROLMODEL), negligible negative (-0.08) for being female (CPNSEX), and low (0.16) for the age of the new member (CPNAGE). The zero order r^2s for these variables are all less than 0.05 or less than 5% of the variation is explained; consequently, these variables are not very important. Other variables with stronger betas include a moderate positive beta (0.38) for hypothesis 10 (GRPACTR), and a moderate negative beta (-0.38) for the nurse's length of time in the position (CPNLENJB). Thus, with these additional variables added to the regression equation hypothesis 10 is supported, CPNLENJB meets the substantive criteria, but hypothesis 12 is not supported.

Table 5 presents the multiple regression analysis for hypotheses 1, 3, 5, 7, 11, and 13. All independent variables together (GRPACTR, GRPDOL, OBSTRAT, GRPCOMPR, MAINTROL, and ROLMODEL) explain a substantial 84% of the variation in the proportion of time the nurse spends with adult psychotic patients (ENACTROL). The betas are negligible (-0.08) for hypothesis 1 (GRPACTR), low (0.18) for hypothesis 3 (GRPDOL), (0.12) for hypothesis 5 (OBJSTRAT), (0.12) for hypothesis 7 (GRPCOMPR), and (0.11) for hypothesis 11 (MAINTROL);

and, strong (0.68) for hypothesis 13 (ROLMODEL). Each of these betas is less than the bivariate r; GRPDOL and OBJSTRAT show the greatest drop. In the multivariate analysis hypothesis 13 is strongly supported; hypothesis 3 is weakly supported; and hypotheses 5, 7 and 11 are marginally supported; but hypothesis 1 is unsupported. The prior support for hypothesis 1 is due to the combined effects of all independent variables on ENACTROL; alone GRPACTR has little effect on ENACTROL.

TABLE 5

Simple and Multiple Regression Analyses for Hypotheses 1, 3, 5, 7, 11, & 13

Independent Variable	Dependent Variable	r^a	r^2	$Beta^b$	H	Support
GRPACTR	ENACTROL	0.12	0.01	-0.08	1	No
GRPDOL	ENACTROL	0.69***	0.48	0.18	3	Yes
OBJSTRAT	ENACTROL	0.57*	0.32	0.12	5	Yes
GRPCOMPR	ENACTROL	0.22	0.05	0.12	7	Yes
MAINTROL	ENACTROL	0.26	0.07	0.11	11	Yes
ROLMODEL	ENACTROL	0.88***	0.77	0.68**	13	Yes

$R^2 = .84$**
($R^2c = .75$)
*p<.05
**p<.01
***p<.001
[a]Bivariate analysis
[b]Multivariate analysis

Summary of Hypotheses

Figure VII summarizes and displays all hypothesized and exploratory relationships. The division of labor (GRPDOL) and the stratification (GRPSTRAT) of the group increase as the size of the group increases (GRPSIZE). The group's acceptance of the new role (GRPACTR) increases mainly as the proportion of doctors and nurses in the group increases (GRPCOMPR), and increases to a much lesser extent as the division of labor increases, but is unaffected by the stratification of the group.

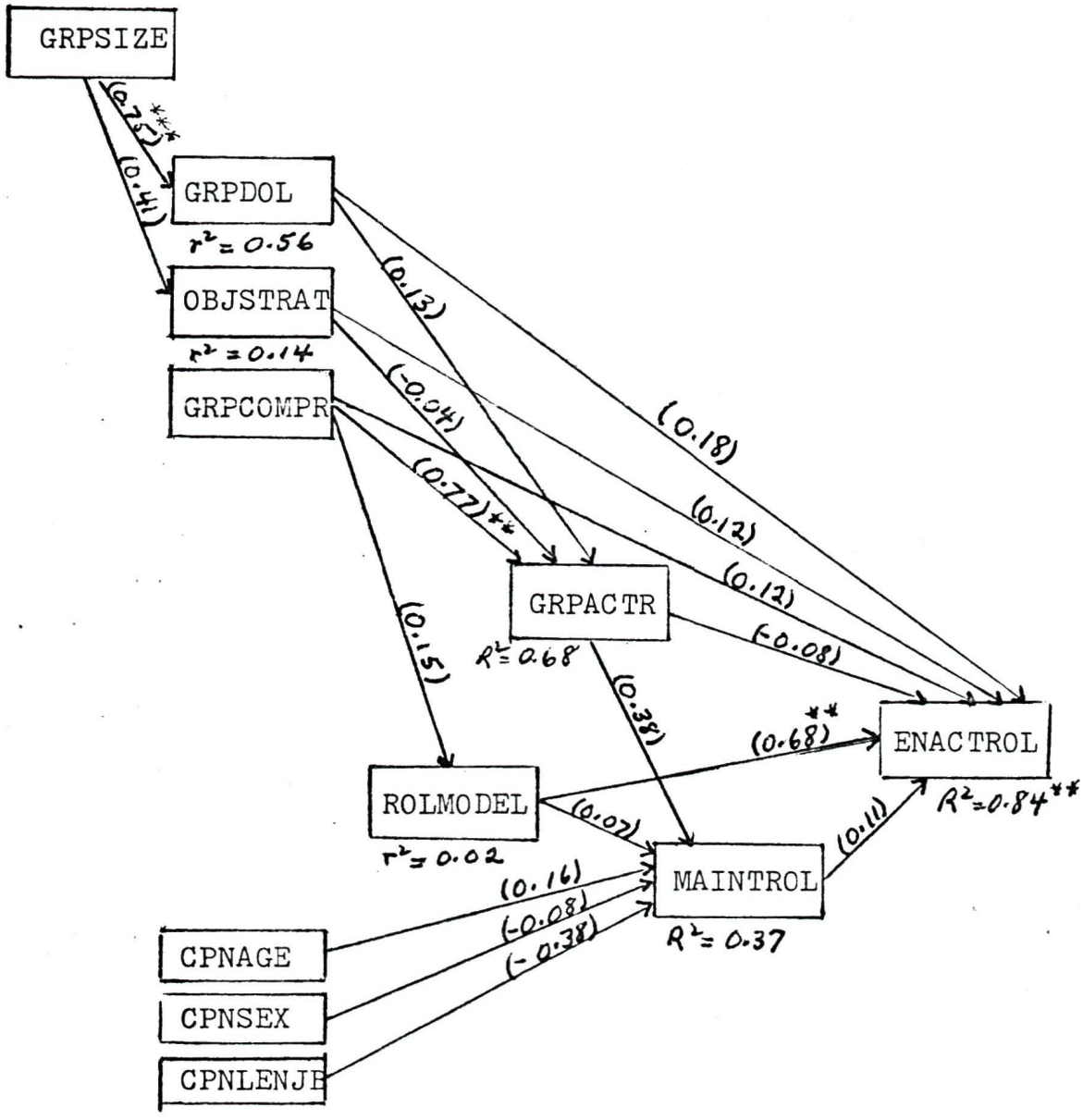
The identification of a doctor or a nurse as a role model or coach (ROLMODEL) tends to occur as the proportion of doctors and nurses increases.

The nurse's willingness to care for adult psychotic patients (MAINTROL) tends to increase as the group's acceptance of the new role increases and the nurse's length of time in the position (CPNLENJB) decreases; and to a lesser extent as the nurse's age increases (CPNAGE). The nurse's sex (CPNSEX) and identification of a doctor or nurse as a role model have very little or no effect on the nurse's willingness.

The proportion of the nurse's time spent with adult psychotic patients (ENACTROL) tends to be high when the nurse identifies a doctor or a nurse as a role model or coach. To a much lesser extent, the proportion of the nurse's time spent with adult psychotic patients tends

to increase as the division of labor, the stratification, the proportion of doctors and nurses, and the nurse's willingness increase; however, the group's acceptance of the new role has little if any effect.

Figure VII: A Summary Diagram of All Hypothesized and Exploratory Relationships (betas are in parentheses).



*p .05
**p .01
***p .001

Further Analyses of Variables Affecting ENACTROL

Table 6 shows the multiple regression analysis of a more parsimonious explanatory model than in Table 5. Hypothesis 1 (GRPACTR) which is not supported in Table 5 is excluded. The amount of variation explained is the same: 84%. Compared to the betas in Table 5 the betas for hypotheses 5 and 13 increase, and the betas for hypotheses 3, 7, and 11 decrease. The betas now are negligible (0.06 and 0.09) for hypotheses 7 (GRPCOMPR) and 11 (MAINTROL); low (0.16 and 0.13) for hypotheses 3 (GRPDOL) and 5 (ROLMODEL); and strong (0.70) for hypothesis 13 (ROLMODEL). In this reduced model hypothesis 13 continues to be strongly supported, hypotheses 3 and 5 are weakly supported, and hypotheses 7 and 11 are unsupported.

TABLE 6

Simple and Multiple Regression Analyses for Hypotheses 3, 5, 7, 11, and 13

Independent Variable	Dependent Variable	r^a	r^2	Beta[c]	H	Support
GRPDOL	ENACTROL	0.69***	0.48	0.16	3	Yes
OBJSTRAT	ENACTROL	0.57*	0.32	0.13	5	Yes
GRPCOMPR	ENACTROL	0.22	0.05	0.06	7	No
MAINTROL	ENACTROL	0.26	0.07	0.09	11	No
ROLMODEL	ENACTROL	0.88**	0.77	0.70**	13	Yes

R^2= 0.84***
(R^2c = 0.77)
*p<.05
**p<.01
***p<.001
[a]Bivariate analysis
[b]Multivariate analysis

Table 7 displays the multiple regression analysis of an even more parsimonious model than in Table 6. The two unsupported hypotheses 7 (GRPCOMPR) and 11 (MAINTROL) are excluded. The amount of variance explained is still the same: 84%. Compared to the betas in Table 6, the beta for hypothesis 3 increases substantially, but for hypotheses 5 and 13 the betas decrease. The betas now are zero for hypothesis 5 (OBJSTRAT), moderate (0.35) for hypothesis 3 (GRPDOL), and strong (0.66) for hypothesis 13 (ROLMODEL). Hypothesis 13 is substantially supported and hypothesis 3 is moderately supported, but hypothesis 5 is unsupported.

TABLE 7

Simple and Multiple Regression Analyses for Hypotheses 3, 5, and 13

Independent Variable	Dependent Variable	r^a	r^2	Beta[b]	H	Support
GRPDOL	ENACTROL	0.69***	0.48	0.35	3	Yes
OBJSTRAT	ENACTROL	0.57*	0.32	-0.00	5	No
ROLMODEL	ENACTROL	0.88***	0.77	0.66**	13	Yes

R^2=0.84**
(R^2c = 0.82)
*p<.05
**p<.01
***p<.001

[a]Bivariate analysis

[b]Multivariate analysis

Table 8 shows the most parsimonius regression equation explaining ENACTROL. Hypothesis 5 (OBJSTRAT) which is unsupported in Table 7 is excluded. Now, two independent variables, ROLMODEL and GRPDOL, explain 84% of the variation in ENACTROL. This is the same amount of variation explained by 6 independent variables in Table 5. The beta for hypothesis 3 (GRPDOL) is moderate (0.35) and for hypothesis 13 (ROLMODEL) is substantial (0.66); that is, when the effects of the other variable is controlled GRPDOL has a moderate effect and ROLMODEL has a substantial effect on ENACTROL. The results of this multiple regression analysis continue to support hypotheses 3 and 13.

TABLE 8

Simple and Multiple Regression Analyses for Hypotheses 3 and 13

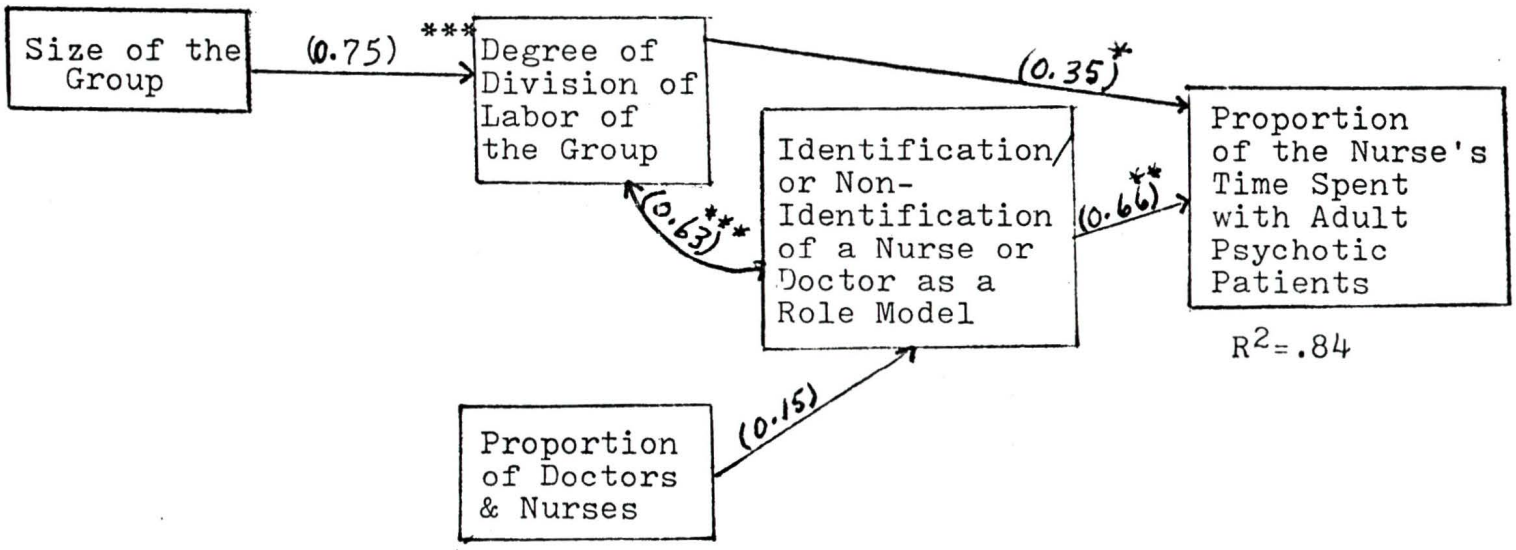
Independent Variable	Dependent Variable	r^a	r^2	Beta[b]	H	Support
GRPDOL	ENACTROL	0.69***	0.48	0.35*	3	Yes
ROLMODEL	ENACTROL	0.88***	0.77	0.66**	13	Yes

$R^2 = 0.84$**
($R^2c = 0.83$)
*p<.05
**p<.01
***p<.001
[a]Bivariate analysis
[b]Multivariate analysis

GRPDOL and ROLMODEL in the correlation matrix (Appendix E) have a substantial positive correlation (0.63). Partial correlation analysis of these variables with ENACTROL adds little information as it shows the same rankings as the partial regression coefficients in Table 8. The effects of these two variables on ENACTROL are independent with ROLMODEL having a much stronger effect than GRPDOL.

The most parsimonious explanatory model and causal sequence leading to role enactment (ENACTROL) is shown in Figure VIII. The larger the group is (GRPSIZE), the higher the division of labor (GRPDOL) tends to be, and a high division of labor is associated with the identification by the nurse of a doctor or a nurse as a role model or coach (ROLMODEL). The identification of a doctor or a nurse as a role model also tends to occur when the proportion of doctors and nurses (GRPCOMPR) in the group is high. A high proportion of the new nurse's time tends to be spent with adult psychotic patients mainly when a doctor or a nurse is identified by the new nurse as a role model or coach and to a lesser extent when the division of labor of the group is high.

Figure VIII: The Most Parsimonious Explanatory Model of the Proportion of Time the Nurse Spends with Adult Psychotic Patients. (betas are in parentheses)



*p<.05
**p<.01
***p<.001

Chapter IV

DISCUSSION

The main thesis of this study is that both group and individual level variables, with group level variables being of particular importance, affect the degree of enactment of a new role by a new member in a small group located within a formal organization. This thesis is generally supported, however, group level variables per se do not have the greatest impact.

Individual Level Variables

The role model or coach identified by the new member has the greatest influence on the enactment of the role. "The role model or coach is a socializing agent who helps new members learn "knowledge and skills...that enable them...to participate as effective member(s) of groups" (Goslin, 1969:2). According to Mills (1967:88) during the first stage of entry to a group the newcomer "operates within behavioral roles"; that is, he follows the behaviors of others. Therefore, it follows logically that the member who helps the new member learn the role he is to enact in the group, affects the enactment of that role. In this study, group members who are from a related occupation and who can enact some of the new role behaviors, that is, doctors and nurses, are the role

models or coaches who have the greatest effect on the enactment of the new role by the new member.

The role model or coach is so important in explaining the enactment of the new role that other processes besides socialization may occur. Mills (1973:261) studied the addition of a newcomer to 3-person groups. He found that the newcomer integrates easily into groups in which members all have strong or moderately strong friendly relationships, and into coalitions where there is a mixture of friendly and hostile relationships. Izraeli (1977:142) also discussed the importance of coalitions. She pointed out that the coalitions formed by the new member facilitate the enactment of his new role and his acceptance into the organization. Similarly, the newcomer in this study, if he is not in a totally friendly group, may enter an existing coalition or form a new coalition with a group member. The role model or coach likely is involved not only in helping the new member learn his new role, but also may form a coalition with the new member which may further affect the enactment of the new role.

The identification by the new member of a role model or coach who is from a related occupation is affected by a group level variable. When the proportion of members of a related occupation, doctors and nurses, is high, the nurse tends to identify a doctor or a nurse as a role model. However, this effect is

weak, possibly because only one role model can be identified; therefore, so long as one member of a related occupation is in the group he could be identified.

Other factors than the proportion of members of a related occupation may be affecting the role model identified by the new member. For example, division of labor, a structural variable existing before the new nurse enters the group, has a strong relationship with the role model identified. It may be that in groups with a high division of labor that group members of a related occupation, doctors and nurses, who are enacting some of the role behaviors of the new role, may encourage the new members, new nurses, to take over these role behaviors; subsequently, freeing themselves for greater specialization. That is, a group structure with a high degree of division of labor or specialization encourages further specialization (Archibald, 1978:20) in its members.

Another individual level variable, the new member's willingness to enact the role has little effect on role enactment. That is, what the new nurse is willing to do has little effect on what he actually does. This is similar to La Piere's (1934) finding that what people say they will do and what they actually do may be different.

The new member's willingness, however, is affected by a number of variables. The greater the group's acceptance of the new role, the shorter the time the nurse is in the position, and to a lesser extent the older the nurse, the more willing he is to enact the new role. The nurse's sex and role model have little effect. One interpretation of this last finding regarding the role model is that the member of a related occupation, the doctor or nurse, is not willing to enact the new role either, but does help the new member, the nurse, learn the new role (as noted in the high degree of role enactment associated with these members as a role model).

Group Level Variables

Group level variables have very weak to moderate effects on role enactment. The strength of group norms accepting the new role has very weak if any effect on the degree of role enactment. This may occur because the operational measure for group acceptance is very general; Rokeach (1968:135) suggested that specific attitudes to particular situations are more useful than general attitudes in predicting behavior. And, Ajzen and Fishbein (1977:916) in an empirical cumulation of 109 studies found that to "predict behavior from attitudes, the investigator has to ensure high correspondence between at least the target and action elements of the measures he employs"; in this study correspondence

between the target and action elements is low to moderate. In regard to norms specifically, Blake and Davis (1964:456) pointed out that behaviors may differ from norms "unless some effort or force is exerted to bring about conformity"; sanctions are not elicited in this study.

The failure of the norms or the degree of acceptance of the new role to effect role enactment may be due to any one or to some combination of the above measurement problems; or, it may be that the strength of group norms accepting the new role has no effect on role enactment. That is, whether or not the group accepts the new role doesn't really matter possibly because the new member may be responding to the norms of a subgroup rather than to the norms of the group as a whole. March and Simon (1958:41) pointed out that within an organization "the maintenance needs of the subunits dictate a commitment to the subunit goals over and above their contribution to the whole organization." Similarly, then, a subgroup within the staff group may also "dictate a commitment... to [its] goals," so that, the new member is responding to these norms rather than to the norms of the group as a whole. Since the nurse does not enact the role in the presence of the whole group but may do so within a subgroup, this last interpretation is very plausible.

The strength of group norms accepting the new role is affected, in turn, by a number of variables. As the

proportion of members of a related occupation increases, and as the division of labor increases, the acceptance of the role tends to increase. The first independent variable has the greater effect. The stratification of the group based on occupational prestige has little or no effect, that is, this new role is accepted equally, at a normative level, into groups with high and low stratification. This possibly indicates (1) that either one or both assumptions that the role has low prestige or that the prestige of roles are congruent with occupational prestige, are invalid; or (2) that the occupational (medical-nursing) and specialized aspects of the role are more important than the prestige aspects in affecting the group's norms.

The stratification of the group has weak effects on role enactment. That is, this role fits, at a behavioral level, only slightly better into groups with high stratification than those with low stratification. This is somewhat similar to the above effects of stratification on group norms. And, since the stratification of the group is affected as predicted by the size of the group, it may be inferred that the prestige of the role is not very important.

The proportion of members of a related occupation has a weak effect on role enactment. That is, the nurse's degree of enactment of the new role increases only slightly

as the proportion of doctors and nurses increases. Although this is not a very important variable affecting role enactment, it is important as noted above because of its effects on group norms and on the role model identified by the new member.

In the most parsimonious explanatory model (Figure VIII), when all independent variables except the role model identified by the new member and the degree of division of labor of the group are eliminated from the analysis, division of labor has a moderate effect on role enactment. Division of labor is the most important of the group level variables and the second most important of all variables affecting the degree of enactment of the new role. From this it can be inferred that the specialized aspects of the new role are important and that the enactment of the role fits most easily into a group with a high division of labor. The division of labor of the group is affected, in turn, by the size of the group; so that, as the size increases the division of labor tends to increase.

Although group level variables do not have the greatest effect on role enactment, they have considerable effect on an individual level variable which has the greatest effect. This is partially discussed above, and is shown in the most parsimonious explanatory model (Figure VIII). In this model the proportion of members of a related occupation

as the proportion of doctors and nurses increases. Although this is not a very important variable affecting role enactment, it is important as noted above because of its effects on group norms and on the role model identified by the new member.

In the most parsimonious explanatory model (Figure VIII), when all independent variables except the role model identified by the new member and the degree of division of labor of the group are eliminated from the analysis, division of labor has a moderate effect on role enactment. Division of labor is the most important of the group level variables and the second most important of all variables affecting the degree of enactment of the new role. From this it can be inferred that the specialized aspects of the new role are important and that the enactment of the role fits most easily into a group with a high division of labor. The division of labor of the group is affected, in turn, by the size of the group; so that, as the size increases the division of labor tends to increase.

Although group level variables do not have the greatest effect on role enactment, they have considerable effect on an individual level variable which has the greatest effect. This is partially discussed above, and is shown in the most parsimonious explanatory model (Figure VIII). In this model the proportion of members of a related occupation

and the degree of division of labor of the group have indirect effects on the degree of role enactment through the role model identified by the new member. Overall, then, these group level variables are important because one variable, the division of labor, is the second most important variable directly affecting role enactment; and two variables, the division of labor and the proportion of members from a related occupation, have indirect effects through the role models made available (Inkeles, 1968:121).

Conclusions

The findings from the present study are applicable to the study population, and generalizations beyond this population can only be tentative and speculative pending further research. This is particularly important because although the study involves real people in real working situations, there are only 20 new members and the groups to which they belong.

Future research could be conducted in several directions. First, replication of this present study with other new members enacting new roles in established groups could support, extend, or refute the present findings. A replication could include the following: (1) operationalization of the group's norms variable with a more specific approach; for example, what percent of the new member's time should be spent performing the

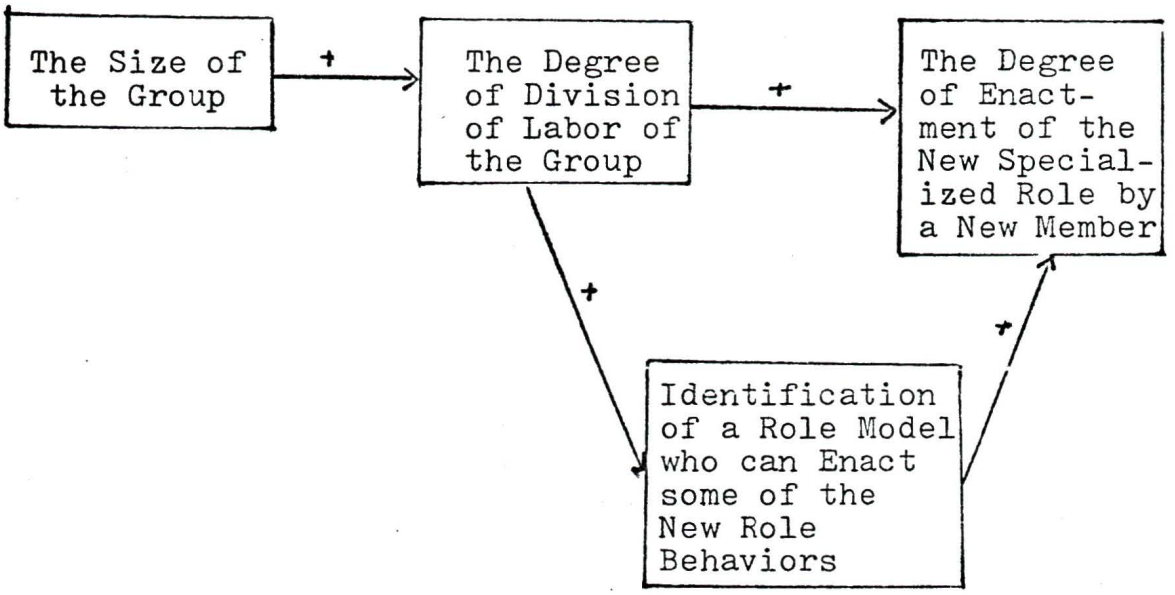
new role? and, (2) the formulation of hypotheses regarding the causes of identification of a role model for the new role; plus, (3) the validation of the prestige of the new role and validation of the congruence of role prestige and occupational prestige in the groups. Second, a follow up study of the present research population could be undertaken to examine changes in role enactment and the factors which may explain these changes.

Third, a new research question arose during the course of the present study: under what conditions will both the role enactment and the new member's integration into the group be high? This question arose because although some of the new members have a high degree of role enactment, they appear to be "marginal men" who are not completely happy with their degree of integration into the group.

What can be learned from this study about the addition of new roles and new members to social structures? In general this study supports previous theories regarding the importance of the role model, coach, or significant other for the person learning a role. When the person learning a role is also a new member to a group, the role model or coach or significant other who is already a member of the group, may also form a subgroup or even a coalition with the new member to facilitate his enactment of the new role. In addition, it appears the process through which the role model is identified, is not random but is, in part, influenced by group structures.

More specifically, this study focuses on a new member who is to enact a new specialized role in a small group within an organization. With some caution, based on our empirical data and pending further research the following model is suggested (see Figure IX).

Figure IX: Tentative Explanatory Model and Causal Sequence for the Enactment of a New-Specialized Role by a New Member in a Small Group.



The main contributions of this thesis occur at both applied and theoretical levels. At the applied level, there is some greater understanding of the conditions under which these nurses enact the new role. At a theoretical level, some support is provided for previous theory regarding the effects of role models, and tentative suggestions are advanced as to the factors affecting the enactment of new specialized roles by new members to small groups.

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Appendix A: Letter to Administrators of Staff Groups not interviewed

February 15, 1979.

Dear

As you probably know, I am at the University of Victoria this year studying toward an M.A. in Sociology. My thesis is on the role of the Community Psychiatric Nurse. I have spoken to Alex Porteous and he has agreed that I can visit all the centers that have the original C.P.N. positions. However, because of time pressures I will not be able to visit every center, but I will meet with each C.P.N. Therefore, I would like to ask you as director of your center to administer these questions for me.

I am enclosing 3 pages of questions. One page, "the Division of Labor Instrument" is to be administered at a staff meeting to professional staff. Please ask your staff to each fill out their own sheet without consultation with other staff. When all sheets are completed please put them in an envelope and seal them in front of your staff, so that they know that no one else at the center will be reading their answers. Then, could you in your role as director answer the "Questionnaire for Interview with all Staff" for the whole center? (2 pages)

These data are essential to help me understand the role of this nurse in our centers. Therefore it is important that each professional staff member at your center fills out this form. Please assure your staff that I will keep all data confidential and that it will be reported only in statistical form.

Once I have determined what my findings are I would be glad to share them with you and your staff if you wish.

Thanks for your cooperation. I know this has been the "year of the questionnaire" but please bear with me and do one more.

Sincerely,

G. G. Spence

Gayle Spence, RN, BScN
(on L.O.A. from SMHC)

Encl.

Appendix B: Letter to Absent Staff

Dear

As you may know, I am at the University of Victoria this year, studying toward an M.A. in Sociology. My thesis is on the role of the Community Psychiatric Nurse.

In order to understand this role, I need to know some things about the centers in which these nurses work.

Since you were not present when I met with the other staff at your center, I would appreicate it if you could fill out the enclosed form and return it to me. This will ensure that your viewpoint will be included in the composite picture for your center.

The information you send me will be kept strictly confidential and will be presented only in statistical form.

Thanks for your cooperation. I know this has been the "Year of the Questionnaire", but please bear with me and do one more.

Sincerely,

G. G. Spence

Gayle Spence.

Appendix C: Interviewer's Schedule for C.P.N.

1. Name _____ Code _____

2. Center _____ Code _____

3. Sex

4. How long have you been in this nursing position in this center?

5. What other professional community experience have you had?

6. What is your present marital status?
   (1) married
   (2) single
   (3) divorced
   (4) separated
   (5) other

7. How old were you on your last birthday?

8. What grade did you complete (at school)?
   (1) less than high school
   (2) high school
   (3) some university
   (4) B.A.
   (5) other (specify)

9. Are you an RN or RPN or both?

10. Have you attended university since you began working here?

11. If yes, how many units have you completed?

12. Any other types of education? (specify)

13. In your professional role as a C.P.N. how many groups of more than 2 people do you meet with on a regular basis? These can be weekly or monthly meetings but must have continued over several months within the past year. These groups could be made up of other professionals, patients, and/or community residents, etc.

14. Please describe these groups:

Group No.	Who	How Often	Purpose	Any reference to psychotic patients

15. Which of the above groups would spend at least some of their time focusing on the needs of psychotic adults?

16. In your professional role as a C.P.N. who do you feel closest to?

17. In your professional role as a C.P.N. who do you consider to be most like yourself?

(probes) patients
C.P.N.s
R.P.N.s
R.N.-psychiatrist
P.H.N.
H. Care Nurses
Psychologists
Psychiatrist
Psychiatric Social Worker
Private physicians
Community residents

18. Who do you talk to when you have problems in your job?

most frequent problems -- who?

other problems ---------- who?

19. On a typical working day, what do you do? Where do you do it and with whom do you do it?

Categories:	who	where	what	Approval
D.S.	child, adol., adult, normal, neurotic, psychotic	center, home, school, hospital	inj, supportive therapy counselling/ therapy	yes no
I.S.	other professionals ph, Dr.		consult.	

20. How do you think that the other staff in the center expect you to spend most of your working time?

21. Now I am going to read back the activities you said you did in a typical working day; I would like you to say if other staff at the center would approve or disapprove of what you did.

22. Does other center staff look after adult psychotics?

23. If yes - would these patients be acute or chronic?

24. If yes - would these patients be mainly schizophrenic or depressed?

25. In your professional role as a C.P.N. are there any activities you have participated in that the staff at this center disagree with?

26. What?

27. If you could do exactly what you wanted to do at this center, what would your professional role be like?

28. When you first started at this center who helped you learn the skills (and knowledge) you needed to do this job? [Profession?]

29. Was this person(s) formally designated to assist you?

30. And now who is the person(s) who helps you learn new skills and acquire new knowledge for this job?

31. Is this person(s) formally designated?

32. Who are some of the people (other than groups of more than 2) who you interact with in your professional role as a C.P.N.?

33. Please rank order these from most time to least time spent with each.

34. If all your direct service time were to be spent with psychotic adults - acute and/or chronic - how long would you stay in this job?

not at all (0), weeks (1), months (4), years (48)

35. What "things" do you think would be helpful to a nurse with such a job?

[car, holidays, salary, other nurses, skills]

36. From your weekly time sheet Feb. 5-9, 12-16, please calculate the number of 1/2 hours you spent: on direct services with all patients/clients (col 32, 33, 34, 35);

37. On direct services with psychotic adults;

38. On direct services for all patients who have been or are in psychiatric hospital (exclude psychotic adults);

39. On indirect services (client consult) for all patients (col 37);

40. On indirect services for psychotic patients/clients;

41. On indirect services for all patients who have been or are in psychiatric hospital (exclude psychotic adults).

Appendix D: Schedule for Interview with All Staff

1. What are the most common kinds of patients/clients seen at this center?

2. Do staff members specialize in particular kinds of clients?

3. For example:

4. Who refers most of your clients to you?

5. Ideally, what does this center consider to be the best use of its time?

6. What happens if a citizen phones and describes a neighbor who sounds psychotic?

7. What happens if a professional phones re a client who is psychotic and at home?

8. What happens when someone is discharged from Riverview Hospital to this community?

9. What functions do you think the CPN in this center should have?

10. What things does the CPN in this center do that are the same as other staff?

11. What things does the CPN in this center do that are different from other staff?

12. If the CPN were not here temporarily (holidays) what happens to her caseload?

13. And new referrals?

14. If the CPN were to leave permanently, what would happen to her caseload?

15. How many hours per week does the staff in this center meet together for staff meetings, case conferences, etc.?

16. Did your center want this position when it was first established? Yes No

17. If a C.P. nurse were only to care for acute and chronic psychotic adults, how many nurses do you think would be needed to handle this type of patient for your center? 0 1 2 3 4

18. Other comments re: the role of this nurse are welcome.

Appendix E: Correlation Matrix for all Variables[a]

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.
1. ENACTROL		20	20	20	20	18	20	19	20	20	20
2. GRPACTR	0.12		14	14	14	18	14	19	20	20	20
3. GRPDOL	0.69***	0.10		14	14	18	14	19	20	20	20
4. OBJSTRAT	0.57*	0.20	0.70*		14	18	14	19	20	20	20
5. GRPSIZE	0.76**	-0.15	0.75**	0.41		18	14	19	20	20	20
6. MAINTROL	0.26	0.42*	0.14	0.20	0.08		18	18	18	18	18
7. GRPCOMPR	0.22	0.74***	0.02	0.27	-0.11	0.21		19	20	20	20
8. ROLMODEL	0.88***	0.02	0.63***	0.43	0.72***	0.16	0.15		19	19	19
9. CPNAGE	0.33	0.07	0.18	0.21	0.08	0.20	-0.14	0.18		20	20
10. CPNSEX	-0.12	0.25	0.15	0.21	-0.14	-0.04	0.19	-0.21	-0.32		20
11. CPNLENJB	0.13	-0.13	0.13	0.27	0.07	-0.42*	-0.00	-0.09	0.08	-0.04	

*p<.05
***p<.001

[a]the lower triangle is Pearson's r,
the upper triangle is the number of cases.

Appendix F: Frequency Distributions*

1. The Proportion of the Nurse's Time Spent with Adult Psychotic Patients

ENACTROL	N	%
0.00 - 0.09	2	10
0.10 - 0.19	1	5
0.20 - 0.29	1	5
0.30 - 0.39	1	5
0.40 - 0.49	1	5
0.50 - 0.59	2	10
0.60 - 0.69	2	10
0.70 - 0.79	1	5
0.80 - 0.89	6	30
0.90 - 0.99	1	5
1.00 -	2	10
	20	100

$\bar{X}$ = 0.62
SD = 0.33

2. The Degree of Group Acceptance of the New Role, Care of Adult Psychotic Patients

GRPACTR	N	%
0.00 - 0.09	1	5
0.10 - 0.19	5	25
0.20 - 0.29	4	20
0.30 - 0.39	7	35
0.40 - 0.49	2	10
0.50 - 0.59	1	5
	20	100

$\bar{X}$ = 0.27
SD = 0.13

*zero for frequency distributions 1,2,3,4,5,6,10 and 11 is the lowest score possible.

3. The Degree of Division of Labor of the Group

GRPDOL	N	%
0.00 - 0.09	0	0
0.10 - 0.19	1	5
0.20 - 0.29	0	0
0.30 - 0.39	1	5
0.40 - 0.49	1	5
0.50 - 0.59	4	20
0.60 - 0.69	13	65
	20	100

$\bar{X}$ = 0.57
SD = 0.11

4. The Degree of Stratification of the Group

GRPSTRAT	N	%
0.00 - 0.09	2	10
0.10 - 0.19	3	15
0.20 - 0.29	5	25
0.30 - 0.39	2	10
0.40 - 0.49	2	10
0.50 - 0.59	6	30
	20	100

$\bar{X}$ = 0.32
SD = 0.16

5. The Proportion of Nurses and Doctors

GRPCOMPR	N	%
0.00 - 0.09	0	0
0.10 - 0.19	0	0
0.20 - 0.29	6	30
0.30 - 0.39	7	35
0.40 - 0.49	2	10
0.50 - 0.59	3	15
0.60 - 0.69	2	10
	20	100

$\bar{x}$ = 0.37
SD = 0.12

6. The Size of the Group

GRPSIZE	N	%
0 - 2	0	0
3 - 5	4	20
6 - 8	3	15
9 -11	6	30
12 -14	5	25
15 -17	2	10
	20	100

$\bar{x}$ = 9.90
SD = 3.81

7. The Degree of Willingness of the Nurse to Spend Time with Adult Psychotic Patients

MAINTROL	N	%
Not at all or minutes	1	5
Weeks	2	10
Months	7	35
Years	8	40
Missing data	2	10
	20	100

Mode = Years

8. The Nurse's Role Model

ROLMODEL	N	%
Doctor or Nurse	12	60
Other	8	40
	20	100

Mode = Doctor or Nurse

9. The Sex of the Nurse

CPNSEX	N	%
Male	5	25
Female	15	75
	20	100

Mode = Female

10. The Age of the Nurse in Years

CPNAGE	N	%
20 - 29	3	15
30 - 39	8	40
40 - 49	8	40
50 - 59	1	5
	20	100

$\bar{X}$ = 37
SD = 6.89

11. The Length of Time in Years that the Nurse has been in the C.P.N. Position

CPNLENJB	N	%
0 - 0.99	6	30
1 - 1.99	0	0
2 - 2.99	1	5
3 - 3.99	1	5
4 - 4.99	12	60
	20	100

$\bar{X}$ = 2.9
SD = 1.84

VITA

Surname: SPENCE Given Names: Georgia Gayle

Place of Birth: N.Battleford, Sask. Date of Birth: March 16, 1941

Educational Institutions Attended, with Dates of Entering and Leaving:

University of Alberta Hospital, Edmonton.	1958 to 1961
University of Alberta, Edmonton.	1961 to 1962
University of British Columbia, Vancouver.	1967 to 1970
University of Victoria, Victoria.	1977 to 1980

Degrees, Diplomas, Etc., Awarded, with Dates and Names of Institutions:

Registered Nurse	1961	University of Alberta Hospital, Edmonton.
P.H.N.	1962	University of Alberta, Edmonton.
B.Sc.N.	1970	University of Alberta, Edmonton.

Honors and Awards:

University of Victoria Fellowship, 1978-79

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Title of Thesis/Dissertation

THE ENACTMENT OF A NEW ROLE BY NEW MEMBERS IN ESTABLISHED WORK GROUPS: THE COMMUNITY PSYCHIATRIC NURSES IN BRITISH COLUMBIA

Author [redacted]

Georgia Gayle Spence

July 15, 1980.