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Communication Attitudes/Leadership: A Correlational Study in interdisciplinary Team Practice: Communication Attitudes and Team Perception of Leadership Behavior

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A Correlational Study in Interdisciplinary

Team Practice: Communication Attitudes and Team Perception

of Leadership Behavior

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THESIS ACCEPTANCE

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Introduction

Health care teams are emerging as the most
effective means of interpersonal information
management in developing patient care strategies . The
comprehensive interdisciplinary approach to teamwork
inspired by Physical Medicine and Rehabilitation draws
representatives from highly specialized fields together
to share information and devise treatment plans in
concert. This unified approach enhances the patient's
rehabilitation program.

Interdisciplinary teams provide a holistic forum
for allied health professionals to collectively work
toward shared goal setting and attainment. Professionals
work toward development of shared goals by acting as
consultants and educators, in their particular area of
expertise in the team setting. The number and variety
of professions represented on the interdisciplinary team

demands that leadership be the responsibility of each team member. Effective team leadership is of paramount importance to the treatment of the patient.

To illustrate the critical import of patient treatment plan development; if a head injured patient were evaluated by individual team members who did not agree to shared goal-setting, the treatment plan may be coordinated. However, in the absence of effective team communication, conflicting therapeutic goals might result. The patient's progress could be inhibited, or at worst could deteriorate.

The comprehensive interdisciplinary approach fosters shared perception on the part of the team, and unidirectional therapy for the patient.

The purpose of the team is to avoid discrepancies in evaluation and discharge goal-setting by devoting all of its resources to the primary task; patient rehabilitation. The team concept addresses two secondary tasks which are derived from the primary task: 1) to treat the patient holistically and 2) to monitor changes in progress patterns and reflect such changes in the overall treatment plan.

The concept of shared responsibility for task and maintenance leadership behaviors in group work is consistent with the interdisciplinary approach to team functioning. Interdisciplinary rehabilitation teams are task oriented and have clearly defined expectations for patient outcomes, the essence of their task. Each of the six interdisciplinary teams involved in this study has virtually the same primary task. The achievement of the task may differ in accordance with the collective leadership abilities of the team.

Social benefits such as professional and emotional support and educational exchange are critical for individual team members and for the team as a system. The helping professional is faced with many emotional issues. The support and endurance of other professionals may help to sustain members who experience personal anguish over such issues.

The team's first meeting on any patient takes place only after a complete evaluation is performed by appropriate members to ascertain the appropriateness of patient referral to the Rehabilitation Hospital, and to identify the types and extent of dysfunction in each

area.

Evaluations are performed individually. Following
the individual evaluations, the team meets as a group.
The presence of representatives from each discipline is
valuable given the importance of the systemic
organization of the interdisciplinary approach. In some
cases individual expertise may not be required upon
admission, however it may later be required as the
patient's condition changes hence there is an emphasis
upon participation by all throughout the team process.

Exchange of members occurs relatively frequently.
Mutual adaptation to personal communication and team
style occurs by all members, thus augmenting the
system's communication patterns. The uniqueness of each
interdisciplinary team and the communication patterns
which differentiate one team from another are the focus
of this study. The project attempts to document
intra-team perception of leadership behavior sharing.
Utilizing this information with individual scores on
the RHETSEN communication attitude encoding scale, the
project attempts to correlate the information to obtain
insight as to how teams communicate effectively, and

whether or not communication encoding attitude sets are linked to perceptions of leadership behavior.

Literature Review

Interdisciplinary Teams. Rehabilitation centers have become one of the new economic meccas of the health care industry. New centers of rehabilitative care are emerging all over the country in a variety of settings, specializing in a variety of disabilities. At the core of this explosive development is the definition of team care.

There are two primary health care team configurations, interdisciplinary and multidisciplinary.

John Melvin (1980) of the Medical College of Wisconsin describes both approaches: "Multidisciplinary: This refers to activities which involve the efforts of individuals from a number of disciplines. These efforts are disciplinary oriented and, although they impinge upon clients or activities dealt with by other disciplines, they approach them primarily through each discipline relating to its own activities... To operate in this setting, one need only know the skills necessary for ones own discipline.

Interdisciplinary: This also refers to activities performed towards a common goal by individuals from a group of different disciplines. However, in this case individuals not only require the skills of their own discipline, but also have the added responsibility of the group effort on behalf of the activity or client involved. This effort requires the skills necessary for effective group interaction and the knowledge of how to transfer integrated group activities into a result which is greater than the simple sum of the activities of each individual discipline..." (Melvin, p.379).

Essentially, the interdisciplinary team member carries responsibility for the patient as well as the communication process which directly effects the outcome of the patient's rehabilitation. For this reason the interdisciplinary team is the overriding preference in the physical medicine and rehabilitation literature.

The team approach is central to the practice of the Physical Medicine and Rehabilitation specialty. The distinction between the interdisciplinary team approach and the multidisciplinary team approach has

been addressed repeatedly in the literature and has become a key issue in the accreditation of new rehabilitation facilities.

It is this systems approach to rehabilitation which sets the communication responsibilities to the test for true interdisciplinary teams. As in all systems, team process is in a constant state of fluctuation. Not only are members exchanged relatively freely, the amount of incoming information regarding patient progress is a determinant in group process. Even in the presence of a designated leader, leadership behavior must vary out of necessity depending upon which professional skills are most needed by a patient at any particular time.

During the course of an individual's rehabilitation, reliance upon certain team members changes with the needs of the patient and team composition. The system must be sensitive to the needs of the patient. Responsibilities must also be modified depending upon the professionals' involvement with any patient. Therefore, effective team communication represents cognition of the needs of the patient, team

members and the team as a whole.

Rintala, Hanover, Alexander, Sanson-Fisher, Willems and Halsted (1986) of Baylor University reported the following benefits to an interdisciplinary approach:

1) Improved communication among the staff

2) Better communication between staff and patient

3) Better decision-making

4) Improved treatment programs

5) Inclusion of the patients' goals in program planning

6) Improved compliance with the treatment regimen by the patient

7) A greater probability of reaching the desired long-range outcomes of improved functioning and a better quality of life.

The Rintala et al. study was conducted with patient participation during medical rounds and addressed only verbal behavior.

Dr. Janet Haas (1986) crystallized the goals of the rehabilitation team: "Rehabilitationists... stress function, promotion of the quality of life, and reintegration into the family and community.

Patients... are taught to cope actively and adaptively with their limitations" (Haas, p. 270).

The patient's quality and satisfaction with life are directly effected by team communication. Monumental expectations are placed on the team by patients and their families. Cohesion and shared responsibility for leadership may serve to lighten emotional burdens of individual team members.   The ethical dilemmas presented on a day to day basis are what religious and political leaders attempt to come to terms with over decades.   "Neglect of these dilemmas may compromise health care, patient autonomy, provider effectiveness, and our country's commitment to care properly for its disabled individuals." (Haas, p. 271).

The Halsted, Rintala, Kanellos, Griffin, Higgins, Rheinecker, Whiteside and Healy (1986) research team provides the impetus for much of the research contained herein. First addressing the importance of the team within the medical community and in particular the hospital setting, they state; "There is little encouragement or reinforcement for; 1) using the team as a creative resource that is a source of satisfaction

to its members, or 2) focusing on how to make the team
as effective and efficient as possible." (Halstead et
al., p.357). In the Halstead research, participation in
team goal-setting was linked to team efficiency and
effectiveness.

Halstead et al. (1986) utilized the rounds process
in the research setting with increased participation
of the allied health care professionals as the research
goal. They designed a planning meeting component
referred to as the core treatment team. The task of
this team was to set team functioning principles such
as restructuring activities, implementing new research
techniques and evaluating their impact. With the new
structure and explicit communication expectations set
for team members, the results pointed to a general
increase in rate of participation in rounds by the
professionals.

Challela (1979, p.10) described some of the duties
of the interdisciplinary team; "responsibility for
assessment, decision-making, delivery of service and
evaluation is shared among the various professionals in
the different disciplines who comprise the

team...Philosophically, it is a service to the client by a shared commitment to the group goals."

The interdisciplinary team represents an open entity in constant exchange with its environment. The principle of General Systems Theory most often addressed in interdisciplinary team work is the principle of nonsummativity. Watzlawick, Beavin and Jackson (1967, p. 125) state, "A system cannot be taken for the sum of its parts; indeed, formal analysis of artificially isolated segments would destroy the very object of interest. It is necessary to neglect the parts for the gestalt and attend to the core of its complexity, its organization.".

Distinct and effective group communication styles have received a great deal of attention in communication literature. Comprehensive interdisciplinary team practice has had far-reaching impact upon communication among specific allied health disciplines. Communication experts and rehabilitationists suggest that promotion of educational and experiential information facilitates interdisciplinary understanding and leadership. "The

fields of rehabilitation are indeed multifaceted and thus call for interdisciplinary participation from the professional community." (Browning p.59).

Horowitz (1970, p. 148) asserts that in interdisciplinary teamwork, "Integrative colleagues "pool their energies and their expertness usually combining forces in a multiplicity of joint operations and ad hoc consultations."

Margolis and Fiorelli (1984, p. 13), discuss the need for interdisciplinary cooperation as the means to developing and executing a responsive rehabilitation process. Four basic communication principles are suggested as guidelines for team meetings:

1. Facts and opinions are embedded in individual perceptual fields.

2. Individuals must work to minimize or alleviate defensive behaviors.

3. Each individual must take ownership in the team goals.

"4. Effective and satisfying communication requires two-way transactions which encourage free,

open, and accurate exchange of information and
ideas."

Margolis and Fiorelli (p. 16) state; "... two way
communication serves the purpose of rehabilitation
more effectively by showing team members that they are
important and can influence team decisions. Feeling
that they have made, or have had the opportunity to
make, a legitimate contribution increases the
commitment of individuals to the team's rehabilitation
goals."

Leadership Professionals are expected to perform
their specialized role in the treatment setting and at
the team meeting. Each is expected to provide leadership
in his or her area of expertise.

Fiedler and Chemers (1974, p.7) discuss leadership
opportunities in terms of the group member who
identifies him or herself as the most qualified in a
particular area. "The member of the group who is clearly
the most qualified will hesitate less in accepting a
leadership position than one who sees others around him
who are or consider themselves to be more qualified."

Fiedler's research on the Least Preferred Co-worker

of the contingency model of leadership suggests that

there is no perfect manner in which to act as leader in

a given situation. There are preferred ways of behaving

in the leadership role. Based upon preferred behavior,

certain situations may yield more success than other

situations in accomplishing the task. "The Contingency

Model leads to the major hypothesis that leadership

effectiveness depends upon the leader's style of

interacting with his group members and the favorableness

of the group-task situation" (Fiedler and Chemers, 1974,

p. 81). If the task is similar, as is the size and

professional constituency of the group, communication

attitudes and perceptions of leadership within the group

may provide information regarding group differences.

In his most recently published conceptual framework

of leadership, Cognitive Resource Theory, Fiedler (1987,

p.1) states, "The quality of leadership is one of the

most important factors in determining the success and

survival of groups and organizations." Cognitive

Resource Theory provides another dimension to the

Contingency Model of Leadership, namely the leader's

cognitive resources in the performance of his or her

duties. As a prelude to the new conceptual framework

Fiedler (1987, p.1) states, "The contingency model has

been justly criticized because it predicts leadership

effectiveness but fails to explain the underlying

processes that result in effective performance."

Margolis and Fiorelli (1984, p. 16) discussed the

responsibility of the team leader as primarily to

emphasize the team task; to devise and implement an

appropriate rehabilitation goal. "In addition, those

with designated or perceived power need to actively

encourage the participation of the other team members

and ought to listen with care to their feelings and

ideas." It may be true that team leaders should be

selected carefully for their ability and willingness to

fulfill this role. It may be even more significant

in determining whom should be appointed the designated

team leader. Willingness of the team members to accept

communication responsibilities may be documented through

the shared perceptions of who is taking leadership and

when in group meetings.

Other factors which contribute to the

communication process, and are key to understanding

the productive operation and longevity of the group are

the effects of team trends in solidarity.   "We would

relate this to such variables as morale and 'atmosphere'

cohesion, the history of cliques, and prevalent

attitudes toward risk-taking, errors and failure, and

the exercise of judgement in the employment of

professional knowledge." (Horowitz, 1970, p. 152).

Naomi Brill (1976. p. 20) describes integrative

practice as characterized by unity of effort,

flexibility of boundaries and freedom to exchange

roles and responsibilities according to need. The

potential positive results from such commitment appear

to be crucial in designating the best approach to

treating patients holistically.   As an operational

definition Brill (p.20) asserts that;   "Team members

communicate, collaborate and consolidate knowledge, on

the basis of which action is taken.   This is the

transactional process, out of which evolves a totality

that is greater than that which can be achieved by any

of the individuals working alone or alone in summation."

What appears to be a non-threatening approach to

team work may also present a dichotomous situation to

individual members. Brill (p. 39) described the dilemma which professionalism may present; "Professionals exercise control over their members through delineation of boundaries in which they may work, through provision of guidelines for this work through required education and through required commitment to certain values and ethics." Central to the individuals' difficulty in understanding the communication role may be that professional expectations have been explicitly defined perhaps to the partial exclusion of team participation in the operational sense. Horowitz (p. 152) agrees, "Diverse conceptions of 'the' professional relationship also are rooted in the ethical codes of the different professions" . Individual interpretation of ethical codes may further complicate the team members' judgement of her/his communication responsibility on the team.

In his discussion on interdisciplinary peers, Fordyce (1981) asserts that part of the process confusion is that professionals hold their principle allegiances with their respective professions yet must perform in an interdisciplinary environment and

participate in the formation of team solidarity. To fortify the unidirectional emphasis of team rehabilitation goals, he suggests that team members replace the profession as the individual's reference group.

Rhetorical Sensitivity. The notion of complexity of the individual and of the interaction was addressed by Hart and Burks (1972, p. 75): "Our assumption here derives from a frankly general semantics perspective, one which sees all men as multi-ordinal, indexed social creatures who are necessarily, many things to many people. Such a point of view treats a person not as an entity but rather a collection of (oftentimes regularized), behaviors".

Derived from their description of the complexity and fragility of human interaction, Hart and Burks (1972) presented the concept of Rhetorical Sensitivity. The concept of Rhetorical Sensitivity relates to an "ideal" set of personal attitudes toward spoken messages. It represents a thought process about what should be said and how it should be presented verbally. The concept describes attitudes which may be

demonstrated during specific interactions.

Rhetorical Sensitivity as a concept was operationalized through the development of the RHETSEN Scale (Carlson, 1978; Hart, Carlson and Eadie, 1980). The questionnaire and scale for evaluating responses describes a continuum of sensitivity to encoded messages. Three basic points of the continuum which represent an individual's potential attitude set about interactions are utilized. The three points labelled Rhetorical Sensitive, Noble Self and Rhetorical Reflector, must be viewed in combination to gain an understanding of each individual's particular communication orientation.

Rhetorical Sensitive: Rhetorically sensitive persons demonstrate their individual complexity by reacting differently in specific situations. They show many sides of their total personality. Darnell and Brockreide (1976, p. 180) describe the rhetorically sensitive person. "The empathy of sensitive persons is neither purely adoptive nor purely projective: indeed for this sort of person the distinction between the two is meaningless. Whatever the starting point... the

feelings of both are joined." They continue,"...they

engage in a transaction in a merging of perspectives out

of which is to come a series of shared choices."

Noble Self: The second attitude set in the RHETSEN

Scale refers to Noble Self or that aspect of attitude

which is directed at the primary communication needs of

the individual. "Because self is viewed as singular the

integration of one's parts and the consistency among

them are very important objectives, and Noble Selves

make choices to meet those criteria. Such persons see

any variation from their personal norms as

hypocritical..." (Darnell and Brockreide, p. 176).

Noble Selves anticipate the same attitudes from their

communication partners.

Rhetorical Reflector: Rhetorical Reflectors appear

to be the antithesis of the Noble Self. "...Reflectors

represent pluralism gone wild. They have no self to

call their own... If the preparation is effective and

the attribution of the other person's choices is

accurate, they hope to please the other person and be

liked; pleasing others and being liked are important to

Reflectors." (Darnell and Brockreide, p.178).

Hart and Burks (1972) described contemporary views toward communication as either expressive or instrumental. Rees and Segal (1984) refer to leader roles with the same labels, "instrumental roles, those that are involved with the achievement of the task goals of the group: and expressive roles, those that are involved with the internal integration of group members. Upon primary research with members of football teams, these researchers found that identified leaders exhibited both expressive and instrumental leadership. Hart and Burks (p.75) suggest that the instrumental approach termed 'rhetorical' throughout their work, "...best promises to facilitate human understanding and to effect social cohesion."

Purpose of the Study

Health care teams have been described as systems which exhibit the unique tendencies of systems. They behave as only they can through the unique interdependent relationship of their membership. This project attempts to explore perceived leadership behavior within interdisciplinary health care teams and

communication encoding attitude sets of individual team members.

In essence the project attempts to determine if there are perceived group leadership correlates to individual group members communication attitudinal sets.

The primary research questions will be; Do teams deviate in perception of occurrence of leadership behavior in overall frequency of mentions and types of responses given? Is the perception of leadership related to communication attitudes of group members? Are there significant differences among groups in terms of individual assessment of leadership behavior? Are there particular communication attitude constructs which tend to be associated with perceived leadership behavior?

Chapter II

Methodology

Subjects and Setting

The study was carried out through participation of six comprehensive interdisciplinary Physical Medicine and Rehabilitation teams. Each team provided 100% response to the instruments used in the study. There were 38 subjects in all, and due to duplication of personnel on teams, the total number of responses yielded was 53. Subjects are listed by department;

Nursing	16
Physical Therapy	4
Social Services	2
Psychology	3
Dietary Services	2
Speech Pathology	4
Occupational Therapy	5
Recreation Therapy	2

The project site was Madonna Rehabilitation Hospital, Lincoln, Nebraska. The 44 bed rehabilitation hospital is served by six comprehensive interdisciplinary rehabilitation teams.

Instruments

The 45-item RHETSEN scale, (Carlson, 1978) was
utilized to document communication encoding attitude
sets of members of the interdisciplinary teams. Each
item is presented in the Likert fashion. Each item
presented 5 response options; A-Almost always true,
B-Frequently true, C-Sometimes true, D-Infrequently
true, and E-Almost never true (See Appendix A).
Responses were scored differently using the key
developed by Carlson (1978).

The Leadership Behavior Tool was derived from the
model utilized for the Health Team Development Program
developed by Rubin, Plovnick and Fry, (1975). The
instrument is used to measure perception of Leadership
Behavior as documented by members of the team.
Self-reports were not included in the data. The tool
provides a matrix to each team member in which to
identify members of a particular team who take
responsibility for specific task and maintenance
behaviors. The authors describe task-oriented behaviors
as the WHAT of team function and maintenance-oriented
behaviors as the HOW of team function (Rubin Plovnick

and Fry, 1975).

The matrix provides ten categories of behavior.
There are six categories of task-oriented behaviors
(TOBs):   1) Initiating

2) Information seeking and giving

3) Opinion seeking and giving

4) Clarifying and elaborating

5) Summarizing

6) Consensus Testing

and four categories of maintenance-oriented behaviors
(MOBs):   1) Gatekeeping

2) Encouraging

3) Harmonizing

4) Compromising

The instructions were provided by the researcher,
paraphrased and in shorter version than those provided
in the workbook (Rubin, Plovnick and Fry, 1975), (See
Appendix B).

In addition to the RHETSEN instrument and the
Leadership Behavior Tool, demographic questions relating
to length of employment, professional field of
practice,sex, and team membership were asked of each

respondent.

Constraints

Due to the complexity of interdisciplinary health
care teams, several constraints unique to the teams
themselves should be noted. Each health care team
provides a similar service to its patients. Some of the
teams specialize in one particular area, although each
team serves a congruent population of patients. Those
teams which specialize in certain disorders, head trauma
for instance, are charged with acting as consultants to
other teams which may be serving head trauma patients.
The enormous time and energy commitments required by
some patient populations dictates that assignment of
patients to teams be varied. Therefore there may be
differences in the amount of bonding which teams may
have experienced, especially through shared educational
experiences. During the implementation phase of new
treatment programs, teams may have had the opportunity
for educational experiences as a group, and therefore
may be better able to assume their shared leadership
responsibilities.

Team membership is generally constant at over 11

individuals per team, however, members present on the
day on which the project instruments were distributed
ranged from six to eleven individuals. Core team
meetings, the setting for this project, may be
disproportionate in terms of representation from some
disciplines. For example, there may be six
rehabilitation nurses assigned to a single team. It is
an expectation that at least one of the nurses from this
area be present during all such team meetings. Such
disproportions may influence the outcome of this
research.

Both the RHETSEN Scale and the Leadership Behavior
Tool were distributed during regularly scheduled
meetings.

To provide a balance in the distribution of tools,
half of the teams, received the RHETSEN Scale first in
the packet while the remaining three teams received the
Leadership Behavior Tool first in their packets. There
were no instructions regarding which item was to be
completed first.

Potential differences in educational and
professional backgrounds have been discussed in the

Literature Review. There are eight professional

disciplines represented in the research.

Participants numbered 38 for the RHETSEN scale.

Each respondent to the RHETSEN scale was

requested to complete the questionnaire only one time

during the study. Due to the duplication of personnel

among groups, the second part of the procedure,

(Leadership Tool), was completed more than once by

several respondents.

There are six health care teams involved in the

study. Some have designated specialties while others

work with a variety of disorders. Designations are as

follows:

Lambda: Head Trauma Rehabilitation

Sigma: Cerebral Vascular Accident

Rehabilitation

Kappa: Arthritis Rehabilitation/no

designation

Theta: Burn Rehabilitation

Chi: No designation

Rho: No designation.

For purposes of confidentiality the teams have been

assigned numbers not necessarily in the order in which they appear here.

As previously stated, many of the teams consisted of common members. Many areas employ less than three members. Therefore, these members participated on more than one of the six teams. The number of Leadership Tool responses depended upon the respondents availability on the days the tools were utilized.

Procedure

Each subject completed the RHETSEN scale one time. In addition, each subject completed the Leadership Behavior Tool in each team setting yielding 53 responses to this tool. The entire project was carried out in 2 consecutive working days during regularly scheduled team meetings.

The participants were provided both verbal and written instructions. Verbal instructions began with a short description of the project. Subjects were assured that written permission for the project had been obtained from the institution's internal research approval team and that confidentiality of information was guaranteed through the use of identification

numbers.

The researcher guaranteed that each member who participated in the study did so voluntarily and that refusal to participate would not be reported to any authority.

At the outset of the study the team members present were asked to give their names which were then written on the chalk board and clearly visible to all team members present. They were then asked to identify absent members. Absent team members were identified as those who had met with the team at least two times within 60 days previous to the study, and included on the membership list written on the chalk board.

All members present at the team meeting were considered team members. All had been present at least two times within the previous sixty days. The purpose of writing members names on the chalk board was to provide a listing of individuals who could be considered contributors to task and maintenance responsibilities of the group, and therefore were eligible for mention on the Leadership Behavior Tool.

Coded packets were distributed to team members.

The first 3 teams received packets where the RHETSEN scale was presented first while the second 3 teams received packets in which the Leadership Behavior Tool appeared first.

The researcher verbally introduced both tools as being self-explanatory. The RHETSEN scale displayed instructions on the top of the one-page scale (See Appendix A). The Leadership Behavior Tool was accompanied by a two-paged set of instructions (See Appendix B). Team members were asked to utilize the names written on the board to respond to the Leadership Behavior Tool. The researcher requested that no discussion take place during the task performance.

Chapter III

Results

A total of 38 individuals were included in the study. Inclusion in the study was determined by completion of the RHETSEN scale and the Leadership Behavior Tool for participation in at least one team meeting. Several of the 38 participants are members of more than one rehabilitation team, and therefore completed the Leadership Behavior Tool more than one time, yielding 53 total sets of responses. 'Sets of responses' refers to the Rhetsen Scale response coupled with each Leadership Behavior Tool completed by the respondent. Of the 53 total participants, 9 are male and 44 are female.

Table 1 indicates the number of respondents included in the study by discipline, the number responding to the RHETSEN scale and the number responding to the Leadership Behavior Tool.

Table 1

Participation by Discipline

DISCIPLINE	# of Respondents (RHETSEN)	# of Respondents (Leadership Tool)
Nursing	16	19
Physical Therapy	4	4
Social Services	2	6
Psychology	3	7
Dietary Services	2	3
Speech Pathology	4	4
Occupational Therapy	5	5
Recreation Therapy	2	5
Total	38	53

Length of employment for all included in the study ranged from less than 1 year to 8 years. The mean length of employment was 3.17 years.

To calculate task leadership and maintenance leadership scores the following procedure was used. The number of times a person was mentioned on the Leadership Behavior Tool by the other members of his or her team was counted. This total was divided by the total possible times a person could be mentioned. The

result was a percentage of times the person was mentioned as exhibiting leadership behaviors.

Table 2 shows the averages of the six teams in terms of leadership percentage scores.

Table 2

Task/Maintenance Mean Scores

Team #	Task/ Mean	Mntnce/Mean
1	.2755	.3264
2	.2662	.2257
3	.4056	.2500
4	.3218	.2188
5	.2037	.1306
6	.2407	.1278
All	.2764	.2079

The actual number of individuals mentioned as exhibiting each of the ten leadership behaviors for each of the six teams is presented in table 3. Also reported in table 3 is the percentage of individuals mentioned out of the possible number who could be mentioned for each behavior for each team.

Table 3
Leadership Behavior - Team Responses

Team	1	2	3	4	5	6	All
Task Oriented							
Initiate	14	20	22	31	25	27	139
%	5	8	13	12	13	13	10
Info-Skg	47	46	36	44	26	50	249
%	19	18	20	17	14	23	19
Opin-Skg	34	50	31	41	33	27	216
%	14	20	18	16	17	12	16
Clar/Ela	16	16	21	29	18	29	129
%	6	6	12	11	10	13	10
Summ	12	22	13	17	18	15	97
%	5	9	7	7	10	7	7
Cnsnsus	14	18	14	19	14	17	96
%	6	7	8	7	7	7	7
Total	137	172	137	181	134	165	926
%	55	68	78	70	71	75	69
Maintenance Oriented							
Gtkping	46	19	8	17	7	6	103
%	18	8	4	7	4	3	7
Encour	22	15	11	19	10	13	90
%	9	6	6	7	5	6	7
Harmon	20	22	10	17	20	18	107
%	8	9	6	7	11	8	8
Comprom	24	24	10	22	16	18	114
%	10	9	6	9	9	8	9
Total	112	80	39	75	53	55	414
%	45	32	22	30	29	25	31
ALL RESP	249	252	176	256	187	220	1,340

From Tables 2 and 3, it is clear that individuals providing leadership in the task-oriented behaviors, especially information and opinion seeking were more frequently identified. Mean frequency counts in task-oriented leadership were identified 154.33 times per behavior category compared to maintenance behaviors with a mean frequency of 103.5 times per category. It may well be that information and opinion seeking are the most clearly understood categories and therefore individuals demonstrating such behaviors more readily identified. Even distribution of scores would yield a response rate of 60% in task-oriented and 40% in maintenance oriented behavior categories.

All but one team exceeded the 60% rate in task-oriented behaviors and were lower than 40% in the maintenance oriented behaviors.

In Tables 4 through 9 the Kendall Correlation Coefficients between RHETSEN scores and task and maintenance leadership behavior scores are presented for each of the six teams.

Table 4

Kendall Correlations for Task, Maintenance, RHETSEN

Scores - Team 1

	RS	NS	RR	Task
Task				
Corr	-.4571	.3189	.1494	
	(N 9)	(N 9)	(N 9)	
Sig	*.046	.122	.295	
Maint				
Corr	-.4000	.2609	-.0299	.8571
	(N 9)	(N 9)	(N 9)	(N 9)
Sig	.070	.170	.457	*.001

* Indicates significance of p < .05.

Table 5

Kendall Correlations for Task, Maintenance, RHETSEN Scores -

Team 2

	RS	NS	RR	Task
Task				
Corr	.0588	-.3881	.1213	
	(N 9)	(N 9)	(N 9)	
Sig	.416	.082	.333	
Maint				
Corr	.0896	-.6061	.2770	.7762
	(N 9)	(N 9)	(N 9)	(N 9)
Sig	.374	* .016	.164	* .003

* .Indicates significance of $p < .05$.

Table 6

Kendall Correlations for Task, Maintenance, RHETSEN Scores –

Team 3

	RS	NS	RR	Task
Task				
Corr	-.1380	.2760	.2760	
	(N 6)	(N 6)	(N 6)	
Sig	.351	.222	.222	
Maint				
Corr	-.3581	.2148	.5013	.6671
	(N 6)	(N 6)	(N 6)	(N 6)
Sig	.165	.279	.086	*.037

* Indicates significance of p < .05.

Table 7

Kendall Correlations for Task, Maintenance, RHETSEN Scores -

Team 4

	RS	NS	RR	Task
Task				
Corr	-.0870	-.4482	.8000	
	(N 9)	(N 9)	(N 9)	
Sig	.375	*.050	*.002	
Maint				
Corr	.3529	-.3941	.3769	.5508
	(N 9)	(N 9)	(N 9)	(N 9)
Sig	.101	.080	.084	*.022

* Indicates significance of p < .05.

Table 8

Kendall Correlations for Task, Maintenance, RHETSEN Scores -

Team 5

	RS	NS	RR	Task
Task				
Corr	.1136	-.0698	-.0483	
	(N 10)	(N 10)	(N 10)	
Sig	.326	.393	.427	
Maint				
Corr	-.2201	.1252	.0260	.4891
	(N 10)	(N 10)	(N 10)	(N 10)
Sig	.202	.320	.462	*.032

* Indicates significance of p < .05).

Table 9

Kendall Correlations for Task, Maintenance, RHETSEN Scores -

Team 6

	RS	NS	RR	Task
Task				
Corr	.0238	-.3904	.0964	
	(N 10)	(N 10)	(N 10)	
Sig	.463	.069	.356	
Maint				
Corr	-.0964	.0000	-.2683	.5543
	(N 10)	(N 10)	(N 10)	(N 10)
Sig	.356	.500	.154	*.017

* Indicates significance of p < .05.

Several significant relationships were apparent within specific teams. Teams 1, 2 and 4 each showed significant relationships (p<.05). Each relationship involved different RHETSEN scale scores and dimensions of leadership. Team 1 showed a negative relationship

between task oriented behaviors and Rhetorical Sensitivity scores, while Team 2 demonstrated a strong negative relationship between Noble Self scores and maintenance oriented behavior. Team 4 demonstrated two sets of relationships, both involving task oriented behavior; one, negative correlation with Noble Self scores, and one positive correlation with Rhetorical Reflector scores.

Analyzing the data from all 53 subjects treated as a group (i.e. combining all six teams), revealed no significant relationships between any of the RHETSEN subscales and task leadership or maintenance leadership scores. (See Table 10).

Table 10

Kendall Correlations for Task, Maintenance, RHETSEN

Scores - Combined Teams

	RS	NS	RR	TaskP
Task				
Corr	-.0655	-.0200	.1232	
	(N 53)	(N 53)	(N 53)	
Sig	.251	.420	.108	
Maint				
Corr	-.0697	.0000	.1208	.5696
	(N 53)	(N 53)	(N 53)	(N 53)
Sig	.239	.500	.113	*.000

* Indicates a significance of p < .05.

Likewise no significant relationships were found for the 53 subject group between any of the RHETSEN subscales and overall leadership scores which were obtained by adding together the task and maintenance leadership scores (See Table 11).

Table 11

Kendall Correlations for Leadership & RHETSEN Scores – Combined Teams

	RS	NS	RR
Leadership			
Corr	.0038	.0344	.0092
	(N 53)	(N 53)	(N 53)
Sig	.485	.364	.463

The results of Kendall Correlations between RHETSEN scores and overall leadership scores are presented in Tables 12 through 17.

Table 12

Kendall Correlation for Leadership & RHETSEN Scores -

Team 1

	RS	NS	RR
Leadership			
Corr	-.6873	.5760	.3750
	(N 9)	(N 9)	(N 9)
Sig	*.007	*.020	.094

* Indicates significance of p < .05.

Table 13

Kendall Correlation for Leadership & RHETSEN Scores -

Team 2

	RS	NS	RR
Leadership			
Corr	.0299	.1212	.0308
	(N 9)	(N 9)	(N 9)
Sig	.457	.333	.457

Table 14

Kendall Correlation for Leadership & RHETSEN Scores -

Team 3

	RS	NS	RR
Leadership			
Corr	-.3892	.5449	-.0778
	(N 6)	(N 6)	(N 6)
Sig	.152	.075	.419

Table 15

Kendall Correlation for Leadership & RHETSEN Scores -

Team 4

	RS	NS	RR
Leadership			
Corr	-.4706	-.0606	.4928
	(N 9)	(N 9)	(N 9)
Sig	*.044	.414	*.036

* Indicates a significance of p < .05.

Table 16

Kendall Correlation for Leadership & RHETSEN Scores -

Team 5

	RS	NS	RR
Leadership			
Corr	.0000	.0482	.0500
	(N 10)	(N 10)	(N 10)
Sig	.500	.427	.426

Table 17

Kendall Correlation for Leadership & RHETSEN Scores -

Team 6

	RS	NS	RR
Leadership			
Corr	.0941	-.4340	.2143
	(N 10)	(N 10)	(N 10)
Sig	.358	*.048	.204

* Indicates a significance of p < .05.

Tables 12-17 results are similar to but different from those of Tables 5-9 which treated Leadership

dimensions separately. Tables 12-17 also showed
significant relationships in three of the teams, however
the relationships are different than the ones in Tables
4-9.

Table 12 revealed a significant (p<.05) negative
relationship between leadership scores and Rhetorical
Sensitivity scores and a significant positive
relationship between leadership scores and Nobel Self
scores for Teams 1; Table 4 only showed a significant
negative relationship between task scores and Rhetorical
Sensitivity scores for team 1.

Table 5 showed a significant negative relationship
between maintenance scores and Noble Self scores; but
Table 13 revealed no significant relationships between
leadership scores and RHETSEN scores for Team 2.

Table 15 revealed significant negative
relationships between leadership scores and both
Rhetorical Sensitivity and Rhetorical Reflector scores
for Team 4; but Table 7 showed a positive significant
relationship between task scores and Rhetorical
Reflector scores and a negative significant relationship
between task scores and Noble Self scores for Team 4.

Table 17 revealed a negative significant relationship between leadership scores and Noble Self scores for Team 6; but Table 9 showed no significant relationship between task or maintenance scores and any RHETSEN scores for Team 6.

Mean scores for each of the 3 RHETSEN scale items are listed below by team;

Table 18

RHETSEN Mean Scores and Standard Deviations by Team

Team #		RS	NS	RR
1	Mean	30.8889	13.5556	8.0000
	sd	7.4749	3.8034	2.7643
2	Mean	34.0000	11.1111	6.2222
	sd	5.6372	3.6035	1.7502
3	Mean	34.8333	12.6667	6.6667
	sd	9.6681	5.8501	3.2491
4	Mean	37.1111	10.8889	5.0000
	sd	5.1518	3.2804	3.0551
5	Mean	34.9000	10.5000	8.4000
	sd	10.4611	5.9034	3.0725
6	Mean	38.2000	8.8000	6.1000
	sd	7.0747	1.6155	1.9079

Mean and standard deviation were calculated for the entire N of 53;

Table 19

Mean & Standard Deviation for N=53

	RS	NS	RR
Mean	35.0566	11.1132	6.7547
sd	7.4535	4.5092	3.2870

Chapter IV

Discussion

All six teams provided evidence of a significant relationship between task and maintenance oriented behaviors. Each team, as did the N of 53, exhibited significance, below the .05 level, in the relationship between those behaviors. The relationship was predictable. Encouragement to document both types of leadership behavior was implicit in the instructions which accompanied the packets. Responsibility for participation in the team functioning is included in the job description of each team member.

The most salient result of this project is the inter-team difference in the correlation of perceived leadership behavior among team members and individual communication encoding attitudes as measured by the RHETSEN scale. Throughout the treatment of data, there is evidence of differences between communication attitudes and perceived leadership behavior among most teams. However, when the six teams are looked at as a whole, no consistent relationships are discovered between any type of leadership behavior and

communication encoding attitudes. The results of this study strongly suggest that leadership behaviors and communication attitudes are related, but they are related only in a contingent manner. Contingent upon individual group variables.

The six teams exhibited similarities in RHETSEN scale scores, perception of leadership behavior, and the professional representation on each team. The inter-team differences may be explained utilizing Fiedlers' conceptual framework. Given similar structures, tasks and communication attitudes among their members, interdisciplinary teams may function differently due to the uniqueness of the communication setting.

Table 1 identified the respondents by professional discipline which reflected the general makeup of each team. There were generally a number of nursing representatives present in each team setting, while the other disciplines tended to provide one representative only due to the smaller size of those departments. This also reflects in part the proportion of time spent with the patient. Three nurses may spend three hours per

shift with the patient, while each therapist spends considerable less time with the patient.

Tables 2 and 3 are complementary and serve to highlight the inter-team differences in identification of perceived leadership behavior. Table 2 sets out the potential mean frequency of mentions on the Leadership Behavior Tool by team. Teams 1 and 3 present the two most striking differences in the potential of mention of leadership behavior. They appear to have quite different notions of leadership and how it is portrayed to those teams. Team 1 appears to place a great deal more emphasis on maintenance behavior than on task behavior. The Task/Mean frequency of identification in this group is .2755, compared to the anticipated score of 60% (number of items compared to maintenance 40%) while maintenance mean frequency was fairly close to the anticipated 40% (number of items), at .3264. This is by far the highest team score in the maintenance continuum. Team 3 frequency count is also fairly high on the identification of maintenance behaviors, however, the task behaviors identified were the highest of all teams. These teams appear to have different perceptions of

leadership behaviors, or different methods of
identifying perceived leadership behavior, or these
teams simply exhibit leadership behaviors in very
different ways.

The variance in team responses to the Leadership
Behavior Tool is even more poignant when assessing
Table 3. The Table presents the raw frequency count of
responses by team. It also provides a percentage
breakdown of responses by team. The two teams
identified as exhibiting a great deal of variance in
their responses in Table 2 also demonstrate the greatest
diversity in Table 3, from which Table 2 was derived.
Though the percentages of response might indicate
otherwise, Teams 1 and 3 provided the same number of
responses to the task-oriented portion of the Leadership
Behavior Tool. The obvious difference in the way these
teams operate lies in the number of responses to the
maintenance-oriented portion of the Tool. Here the
responses vary from 112 to 39 and represent 45% and 22%
of the Tool response respectively. The range in
task-oriented behavior is from 55% to 78%, and in
maintenance behavior from 45% to 22%, again, by teams 1

and 3 respectively. The remaining four teams fall between these frequencies.

Another team which warrants attention in the discussion of these two tables is Team 6. In Table 2 which delineates potential mean frequency by task and maintenance behaviors, Team 6 provides the potential for task mention to its members at nearly double the rate of the maintenance mean. When examining the raw scores in Table 3, the rate appears even higher. Seventy-five percent (75%) of Team 6 responses were to the task-oriented section of the Tool while 25% of their responses were to the maintenance-oriented section. It is not suggested that Team 6 appears to function in opposition to the other teams. It is suggested that all three of the teams mentioned in connection with Tables 2 and 3, as well as the teams not mentioned behave differently with respect to leadership on the team.

Relationships among RHETSEN scale scores, (Rhetorical Sensitivity, Noble Self and Rhetorical Reflector) and Leadership Behavior were explored with the Kendall Correlation Coefficient. Table 4-9 outlines the statistical relationships by team. Again, Team 1

appears to stand out. In this instance, there is a negative relationship which shows statistical significance below the .05 level, between task-oriented behavior and Rhetorical Sensitivity. Recalling that this team exhibited the overall lowest score on the task-oriented portion of the Leadership Behavior Tool, the negative significance may be explained by examining the Rhetorical Sensitivity scores. It appears that the higher the Rhetorical Sensitivity scores on the team, the less likely the individual will be mentioned on the task-oriented behavior portion of the Tool.

This may have some import regarding the clarity with which the Rhetorically Sensitive individual sees his or her assignment to the team. Rhetorically sensitive individuals have been described as acting and being appropriate to the situation. As the task of defining rehabilitation goals has been clearly defined for the team, the Rhetorically Sensitive individual may react to the need for maintenance leadership on the team rather than concentrating on task.

Team 1 is not viewed as the most cohesive team by the Supervisor, although individual members tend to

demonstrate a great deal of respect for each others'
professional skills. Team 2, on the other hand displays
a strong negative relationship between maintenance and
Noble Self scores. Team 2, described as generally very
relaxed within the team setting has never been noted for
strict adherence to communication structure within the
team conference setting. This team had
experienced a great deal of staff turnover which may
force them to be more relaxed and less likely to accept
Noble Selves.

Team 4 also displayed a negative relationship. The
negative relationship on this team was between
task-oriented behavior and Noble Selves. Again, the
negative relationships on Teams 2 and 4 provide further
support of the idea that teams operate differently. The
negative relationships are both with Noble Selves,
however the Leadership behaviors involved are quite
different. Team 4 also showed a very strong
relationship. This relationship is between task-oriented
behavior and the Rhetorical Reflector. This
relationship is a positive one and indicates that those
individuals with higher Rhetorical Reflector scores are

more likely to be mentioned on the task portion of the
Leadership Behavior Tool. Team 4 operations appear to
contrast team 2 operations.

Rhetorical Reflector scores and task-oriented
behavior scores were highly correlated (.80) in team 4.
The higher the Rhetorical Reflector scores, the more
likely they were to be mentioned as taking leadership in
task-oriented behaviors. Since Rhetorical Reflectors
have been described as people-pleasers, the taskmasters
they appear to be in this team seems mildly incongruent.
This team may be so task-oriented that completing the
task is the means to gain and maintain good will on the
team.

All three of the significant correlations on Team 4
point to a team which appears to be very task oriented
in a harmonious fashion. The negative correlation of
the Noble Self scores with task-oriented behaviors, and
the highly significant positive correlation among
Rhetorical Reflector scores as well as the fairly high
correlation between task and maintenance behaviors
suggests that this team walks softly but carries a big
stick.   The task orientation is very strong. There may

be a great deal of pressure placed upon individual
members to arrive at agreements as amicably as possible.

In combining the six teams, a percentage conversion
of potential mentions on the leadership behavior tool
was utilized to compare team responses. In Table 10,
the Leadership Behavior Tool was broken out into Task
and Maintenance in exploring the associations within the
two dimensions. Table 11 utilized the Leadership
Behavior Tool as a whole rather than exploring the two
dimensions. When raw scores were converted to potential
response frequency on the two dimensions of the
Leadership Behavior Tool in Table 10, the single
statistically significant interaction was between the
Task and Maintenance scores. This is consistent with
the interaction anticipated between these two dimensions
using raw scores. The interaction between the two in
the conversion reflects the interaction which occurred
in each team in Tables 4 - 9.

Differences in the significant relationships
among teams are not reflected within the Table 10
Combined Teams and the two leadership dimensions, nor
are they reflected in Table 11 where the Leadership

score was utilized.   There are no significant

correlations which serve to explain the specific

differences between team operations.

Utilizing the Kendall Correlation Coefficient

again, each team was treated individually, however, this

time the raw Leadership scores were used in total and

were explored in relation to the three RHETSEN Scale

scores (Tables 12-17).   This time significant

correlations appeared in Teams 1, 4 and 6.   A strong

relationship existed   between Rhetorical Sensitives

and Leadership in Team 1.   As well, a positive

relationship between Noble Self scores and Leadership

was noted on the same team.   There was also a negative

relationship between   Rhetorical Sensitive scores and

leadership on Team 4, though it was not quite as strong

as the Team 1 negative relationship.   On Team 4, a

positive relationship existed between Rhetorical

Reflector scores, and Leadership. Team 6 showed a

statistically significant negative relationship between

Noble Self scores and leadership.

It was reported that there are a few members of

Team 6 who are said to work tirelessly in creating an

enthusiastic climate for team meetings. This team is struggling to develop an identity through the traditional format of team function. The team's growth was inhibited by a confusion of messages and divergent patient care philosophies for some time. This conflict is said to have diverted energies from maintenance and structure issues which has resulted in an as yet immature, but growing team.

Tables 18 and 19 address RHETSEN scores for individual teams and the group as a whole. In Table 18 there appears on the surface to be differences among teams in mean RHETSEN scores (i.e. Team 1 appears to be less Rhetorically Sensitive and more Noble Self and Rhetorically Reflective than Team 6, etc.). However analysis of variance procedures revealed no significant differences (p <.05) in any RHETSEN scores among the six teams.

The RHETSEN means and standard deviations reported in Table 19 are consistent with the norms reported by Carlson (1978) and Hart, Carlson and Eadie (1980) for professionals. Thus the validity of the present study is enhanced. The sample population used in the study is

representative of health care professionals.

Overall the data finds that there are no significant differences among teams in terms of RHETSEN scores, nor in terms of leadership behaviors. Though teams may document such behaviors differently and appear to operate in their own idiosyncratic patterns, the leadership demonstrated through those patterns is a function of the team itself.

Chapter V

Conclusions

Interdisciplinary physical medicine and
rehabilitation teams operate in a world of unknowns
where human trauma is a constant, and active
communication is the primary tool in physical
rehabilitation. As is the mandate of all teams,
cooperation and creative interaction must deliver the
task, the development of an effective rehabilitation
program which is unique to the patient it will serve. A
plan is only as good as the planners and those who will
carry it out. In a like fashion, the team is only as
good as the distinct units which comprise its totality.

Interdisciplinary teams in this study each perform
their tasks in unique ways. Each does perform its task
and each team exhibits leadership behaviors of both task
and maintenance orientation. Teams in this study appear
to perceive the frequency and type of leadership
behavior in different ways. The perception appears to
be related to communication attitudes within some
groups. A verbal description of team operations by the

supervisor provides another dimension to what the team members themselves have told us in the Leadership Behavior Tool. It is the interdependent nature of team members which dictates the life and cycles of the team.

Given the absence of strong association and the absence of significant variation among teams, a logical conclusion from the data presented herein is that Fiedler's Contingency Model of Leadership applies in this setting. There is no communication attitude construct which appears to benefit all teams. Constructs appear to be associated with team behavior only. There is no best communication attitude, which will influence every team in the same way. Similarly, there is none best collection of leadership behaviors which will serve all as well and in the same manner. Interdisciplinary health care teams must develop team specific methods of interaction, and explore interrelationships within to best serve their patients.

Limitations

Information contained within this project is specific to the six physical medicine and rehabilitation teams studied and care must be used in extrapolating

conclusions to analyze or provide insight into the development of other health care teams. The outcome of the correlational study is supportive of the concepts related to the uniqueness of systems and the contingency approach to leadership. It does not provide information about how to select team members, or how best to advise new rehabilitation hospitals in developing team structure.

The project is also limited in its approach to describing the operations of a rehabilitation team. Leadership behaviors are a very limited aspect of team communication and may only serve to identify those who tend to be verbally aggressive during team meetings, though the instructions did not allude to only verbal interaction.

Recommendations for Future Research

The information contained within this project is helpful to the understanding of team functioning. It may also serve to calm the anxieties of those developing new interdisciplinary team components to rehabilitation hospitals. To take the research a step further by exploring the effectiveness of team functioning, a

correlation between RHETSEN Scale scores, Leadership Behaviors, and patient outcomes studies may yield more information as to how the team is actually performing in the interest of the patient.

By gathering more in-depth information from individual team members, such as professional associations, and beliefs concerning professional communication responsibilities in their own disciplines as well as how they view their communication responsibilities as differing the rehabilitation health care team environment may provide yet more information as to how interdisciplinary teams may be developed using more information about specific communication duties.

APPENDIX

LISTED BELOW ARE A NUMBER OF STATEMENTS TO WHICH WE WOULD LIKE YOUR REACTIONS. PLEASE RESPOND TO EACH STATEMENT INDIVIDUALLY AND BE ASSURED THAT THERE ARE NO ABSOLUTELY RIGHT OR ABSOLUTELY WRONG ANSWERS. FOR EACH STATEMENT, PLEASE INDICATE YOUR OPINION BY CIRCLING ONE OF THE FOLLOWING RESPONSES IN FRONT OF THE STATEMENT: A = ALMOST ALWAYS TRUE; B = FREQUENTLY TRUE; C = SOMETIMES TRUE; D = INFREQUENTLY TRUE; E = ALMOST NEVER TRUE.

A B C D E   1. People should be frank and spontaneous in conversation.

A B C D E.   2. An idea can be communicated in many different ways.

A B C D E   3. When talking with someone with whom you disagree, you should feel obligated to state your opinion.

A B C D E   4. A person should laugh at an unfunny joke just to please the joke-teller.

A B C D E   5. It's good to follow the rule: before blowing your top at someone, sleep on the problem.

A B C D E   6. When talking to others, you should drop all of your defenses.

A B C D E   7. It is best to hide one's true feelings in order to avoid hurting others.

A B C D E   8. No matter how hard you try, you just can't make friends with everyone.

A B C D E   9. One should keep quiet rather than say something which will alienate others.

A B C D E   10. You should share your joys with your closest friends.

A B C D E   11. It is acceptable to discuss religion with a stranger.

A B C D E   12. A supervisor in a work situation must be forceful in his or her communication with subordinates to be effective.

A B C D E   13. A person should tell it like it is.

A B C D E   14. "Look before you leap" is the most important rule to follow when talking to others.

A B C D E   15. You should tell a friend if you think they are making a mistake.

A B C D E   16. The first thing that comes to mind is the best thing to say.

A B C D E   17. When conversing, you should tell others what they want to hear.

A B C D E   18. When someone dominates the conversation, it's important to interrupt them in order to state your opinion.

A B C D E   19. You really can't be yourself when talking to your parents.

A B C D E   20. When angry, a person should say nothing rather than say something he or she will be sorry for later.

A B C D E   21. When someone has an irritating habit, they should be told about it.

A B C D E   22. An effort should be made to tell the same thing to different people in different ways.

A B C D E   23. When talking to your friends, you should adjust your remarks to suit them.

A B C D E   24. You really can't put sugar coating on bad news.

A B C D E   25. A person who speaks his or her gut feelings is to be admired.

A B C D E   26. You shouldn't make a scene in a restaurant by arguing with a waiter.

A B C D E   27. Putting thoughts into words just the way you want them is a difficult process.

A B C D E   28. A friend who has bad breath should be told about it.

A B C D E   29. If you're sure you're right, you should argue with a person who disagrees with you.

A B C D E   30. If a woman cheats on her husband, she should tell him.

A B C D E   31. Spoken confrontations with others should be viewed as a last resort.

A B C D E   32. If people would open up to each other the world would be better off.

A B C D E   33. There is a difference between someone who is "diplomatic" and one who is "two-faced."

A B C D E   34. You should tell someone if you think they are about to embarrass themselves.

A B C D E   35. In life you have two choices: to be your own person or to be a "jellyfish".

A B C D E   36. One should not be afraid to voice his or her opinion.

A B C D E   37. If your boss doesn't like you, there's not much you can do about it.

A B C D E   38. You should tell someone if you think they are giving you bad advice.

A B C D E   39. Saying what you think is a sign of friendship.

A B C D E   40. When you're sure you're right, you should press your point until you win the argument.

A B C D E   41. "If you feel it, say it" is a good rule to follow in conversation.

A B C D E   42. If a man cheats on his wife, he should tell her.

A B C D E   43. It is better to speak your gut feelings than to beat around the bush.

A B C D E   44. We should have a kind word for the people we meet in life.

A B C D E   45. One should treat all people in the same way.

LEADERSHIP BEHAVIORS

Instruction Sheet: Rehabilitation Teams

The fact that you are a team means that no single person has all the knowledge and skills necessary to complete your basic task or mission. Coordinated interdisciplinary rehabilitation demands that you organize, coordinate, decide and allocate as a group. Just as no single person can deliver comprehensive health care, no single person can be expected to lead the group in all situations.

The team concept requires leadership from many of its members. You may not make the decision as a member, but may undertake the responsibility of insuring that a decision is made. This can be referred to as shared leadership responsibility.

Please take a moment to read the following descriptions of task-oriented and maintenance-oriented behavior.

Task-oriented behaviors deal with how people behave toward the task-at-hand and include:

1) Initiating: insuring that discussion gets started.

2) Information seeking and giving: providing input and encouraging others to do the same.

3) Opinion seeking and giving: same as above from a personal viewpoint.

4) Clarifying and elaborating: insuring that group members understand input.

5) Summarization: reviewing what has transpired throughout the discussion.

6) Consensus Testing: checking to see if the group is nearing a decision.

Maintenance-oriented behaviors describe how people behave toward each other in accomplishing a task and include:

1) Gatekeeping: regulating communication flow, allowing someone to speak uninterrupted or preventing the same.

2) Encouraging: facilitating others ability to contribute to discussion.

3) Harmonizing: making an effort to avoid conflict.

4) Compromising: recognizing conflict and searching for the best solution in the opinion of the majority.

Please use the attached table to describe which members of <u>this</u> rehabilitation team take responsibility for task and maintenance oriented behaviors. Please fill in the person's full name to the right of each category. Keep in mind more than one person can be responsible for more than one leadership behavior. Include your own name if you feel it is appropriate.

*Don't worry about blank spaces.

*Don't try to balance out the behaviors or concentrate on "giving everybody something".

Please sign your name at the top of the page. I assure you that complete confidentiality will be maintained. If the team is interested in reviewing their responses, I will meet with the team to discuss general responses (without mentioning names). Contact me at Extension 272.

Thank you for your time.

Marie de Martinez

Individual Assessment of How Well the Team is Meeting
Its Needs for TOB and MOB

TOB's	Individuals on the Team Who Perform These Functions Very Well
1. Initiating	
2. Information Giving and Seeking	
3. Opinion Seeking and Giving	
4. Clarifying and Elaborating	
5. Summarizing	
6. Consensus Testing	

MOB's	Individuals on the Team Who Perform These Functions Very Well
1. Gatekeeping	
2. Encouraging	
3. Harmonizing	
4. Compromising	

REFERENCES

Brill, N. I. (1976). Teamwork: Working Together in the Human Services. Philadelphia: J.B. Lippincott Company.

Browning, P. (1982). An Interdisciplinary Program for Preparing Professional Leaders. Journal of Rehabilitation. October/November/December, 57-59, 79-83.

Carlson, R.E. (1978). Rhetorical Sensitivity: Theoretical Perspective, Measurement and Implications in an Interpersonal and Organizational Context. Doctoral Dissertation, Purdue University, Dissertation Abstracts ¬International, 1978, 39, 2615A (University Micro-films No. 78-21, 426).

Challela, M. (1979). The Interdisciplinary Team: A Role Definition for Nursing. Image. 11 (1), 9-15.

Darnell, D.K. & Brockreide W. (1976). Persons Communicating. Englewood Cliffs, NJ, Prentice-Hall, Inc.

Fiedler, F. E. & Chemers, M. M. (1974) Leadership and Effective Management. Glenview IL: Scott, Foresman and Company.

Fiedler, F.E. & Garcia, J.E. (1987). New Approaches to Effective Leadership: Cognitive Resources and Organizational Performance. New York: Wiley.

Fiorelli, J. S. & Margolis, H. (1984). An Applied Approach to Facilitating Interdisciplinary Teamwork. Journal of Rehabilitation. 50 (1), 13-17.

Fordyce, W. E. (1981). ACRM Presidential Address: On Interdisciplinary Peers. Archives of Physical Medicine and Rehabilitation. 62 (2), 51-53.

Haas, J. F. (1986). Ethics in Rehabilitation Medicine. Archives of Physical Medicine and Rehabilitation. 67 (4), 270-271.

Halstead, L. S., Rintala, D. H., Kanellos, M., Griffin, B., Higgins, L., Rheinecker, S., & Healy, J. E. (1986). The Innovative Rehabilitation Team: An Experiment in Team Building. Archives of Physical Medicine and Rehabilitation. 67 (6), 357-361.

Hart, R. P., & Burks, D. M. (1972). Rhetorical Sensitivity and Social Interaction. Speech Monographs. 39 (2), 75-91.

Hart, R. P., Carlson, R. E. & Eadie, W. F. (1980). Attitudes Toward Communication and the Assessment of Rhetorical Sensitivity. Communication Monographs. 47 (3), 75-91.

Horowitz, J. J. (1970). Team Practice and the Specialist: An introduction to Interdisciplinary Teamwork. Springfield, IL. Charles C. Thomas.

Melvin, J. L. (1980). Interdisciplinary and Multidisciplinary Activities and the ACRM. Archives of Physical Medicine and Rehabilitation. 61 (8), 379-380.

Rees, R. C. and Segal, M. W. (1984) Role Differentiation in Groups: The Relationship between Instrumental and Expressive Leadership. Small Group Behavior. 15 (1). 109-123.

Rintala, D. H., Hanover, D., Alexander, J. L., Sanson-Fisher, R.W., Willems, E.P., & Halstead, L.S. (1986). Team Care: An Analysis of Verbal Behavior During Patient Rounds in a Rehabilitation Hospital. Archives of Physical Medicine and Rehabilitation. 67 (4), 118-122.

Rubin, I. M., Plovnick, M. S. & Fry, R. E. (1975). Improving the Coordination of Care: A Program for Health Team Development. Cambridge:Ballinger Publishing.

Watzlawick, P., Beavin, J. H. & Jackson, D.D. (1967). Pragmatics of Human Communication: A Study of Interactional Patterns, Pathologies, and Paradoxes. New York: W.W. Norton.