TRUST IN ORGANIZATIONS

by

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Chapter I

INTRODUCTION

Interpersonal trust is a rare quality, indeed. Few of us feel trusting toward strangers, especially in the large city environment, and those who do, feel trusting toward people for whom there is a frame of reference. In our families we strive to create a climate of trust and openness but we are hesitant to show our vulnerability by openly trusting outside our homes. We teach our children to trust selectively. A dramatically increasing crime rate fosters feelings of fear and alienation. Perhaps, because of this, trustworthiness and openness are qualities we seek out and value in others. As individuals, we feel most comfortable around those we trust and many of us look to psychotherapy to create the feelings of warmth, trust and openness of early childhood.

When we feel it is unsafe to trust, or discover we have trusted unwisely, we defend against attack. We call upon our inner resources to protect and isolate us from possible danger and are likely to react defensively as others approach. "When . . . placed in 'unstructured surroundings' the person is uncertain and threatened since he cannot be sure that a given action will lead him toward a desired goal' (Lewin, 1951, p. 255). This focus and expense of energy leaves little energy available for establishing more satisfying and creative relationships with people. Few of us flourish in a critical, fear producing

environment. Most authors would agree that trust generates trust. "Trust begets trust; fear escalates fear" (Gibb, 1978, p. 16).

The value of trust in interpersonal relationships translates easily to the work environment. If employees feel supported, valued and trusted by their employer, they are more likely to perform optimally, given that the rest of their lives are fairly constant. In support of this idea, some organizations have moved or are moving away from the impersonal autocratic management style of past years to a more humanistic approach, in the belief that in the long run this shift will benefit everyone. Evidence of this shift can be seen in the emergence of such things as improved employee benefits, daycare centers for employees' children, flexible work schedules, career ladder advancement opportunities, and organization sponsored personal counseling services for their employees.

While such services as mentioned above are being used in private sector organizations, hospitals have remained fairly hesitant in following this trend. Nonetheless, there has been a decided move from the traditional hierarchical structure to a participative open process. The traditional measures of a public sector organization's success, such as productivity and output, are not clearly applicable when talking of human service organizations, along with the idea that there is a "particular lack of knowledge about health care agencies as organizations" (Smith, 1972, p. 78). Hospitals have generally been managed autocratically by business men who often have no concept of nurses as professionals or the ethics of patient care. Indeed, until recently nurses have not made themselves heard by the organizational leaders

or consumers of healthcare. These factors have led to a climate of distrust in which open communication is difficult.

Hospitals usually have complex lines of authority with decision-making taking place at the highest organizational levels. For instance, nursing management in hospitals has interpreted and enforced the policies, but staff nurses generally have had little voice in policy development. This has created a climate of distrust and fear. Many nurses have felt supported by administration only if they quietly accepted the philosophy and policies of the organization. This lack of trust in the relationship between nurse and hospital may contribute to lack of job satisfaction and ultimately disenchantment with nursing. Gibb (1978) describes fear as the greatest obstacle to an organization meeting its goals.

Many factors effect the establishment of an attitude of trust in interpersonal or organizational relationships. One factor that dramatically effects organizational climate, is the rapid rate of change, or turbulence in today's society. ". . . Man's organizational relationships today tend to change at a faster pace than ever before" (Toffler, 1970, p. 119). The demand on modern organizations to keep up with change is high. In fact, organizations must creatively deal with many radical changes imposed from outside the organization. Toffler (1970) predicts, "The organizational geography of super-industrial society can be expected to become increasingly kinetic, filled with turbulence and change" (p. 122). Gibb (1978) suggests that the only way for organizations to deal with this kind of turbulence is by creating environments that foster trust and openness.

Because hospitals are especially vulnerable to a rapidly changing, turbulent environment, the time that nurses spend in that environment makes them partricularly vulnerable. Kimberly has said that "The body of knowledge which forms the core of their (nurses) technology changes as research refines and extends the state of the art and/or produces new breakthroughs which enable them to carry out their primary function more efficiently or effectively" (1978, p. 362). It can be assumed that nurses who have stable, trusting relationships with their co-workers and administration will have more energy to put into coping with a turbulent environment that seems to be immune to individual efforts at change.

As hospitals are further confronted with a national environment that demands adaptability and cost-efficiency, they must develop an organizational style that attracts and retains nurses. An organization that fosters confidence, personal growth, self-esteem and trust is likely to appeal to nurses who are willing to make a commitment to the organization and quality patient care.

The climate of trust is one aspect of the organizational climate that has been overlooked by health care organizations. There is a marked paucity of research in the health care field measuring characteristics of the organizational climate that foster growth and adaptability. Measurement of an organizational members level of trust in themselves and the organization might be a logical place to start this exploration.

The purpose of this study is to demonstrate that nursing service personnel experience varying degrees of trust in themselves and their work group, given the present problems with group stability,

environmental turbulence and management style.

Statement of the Problem

The staff of psychiatric units characteristically are very aware of their interpersonal and group interactions and highly value trust, openness, realization, and interdependence in their relationships. It can be assumed that optimal patient care will be provided by a nursing staff that experiences a high degree of trust in themselves and their workgroup. As stated earlier, health care organizations have provided little descriptive research concerning the organizational environment. A great deal of data must be generated before a clear picture of the hospital interpersonal work environment will emerge. This study represents an effort to focus on the need for research involving the context that produces such variable levels of trust.

Review of the Literature

The review will begin with a general discussion of management thought. This will prepare for the discussion of trust to follow. Trust is discussed as a prerequisite of interpersonal growth in terms of individuals and groups.

Organizational Thought--A Historical Perspective

"Surveying the development of management thought, one can see that there has been a trend from autocratic to democratic management and from a focus on efficiency to a greater regard for the well-being of personnel" (Marriner, 1979, p. 30). Although the trend of thought has been toward realizing the human potential, this has seldom been translated into the changes that this philosophy implies for organizations. The Bureaucratic pyramid remains the predominant organizational

structure in this country today. Health care organizations, specifically hospitals, typify the bureaucratic pyramidal organizational structure.

Several theorists have dramatically influenced managers and changed the focus of organizational structure. Organizational theories have grown in complexity and number, as organizations have, over time. The scientific management approach, based on the work of Fredrick Taylor, focused on "Maximum efficiency and minimum human effort" (Smith, D., 1972, p. 20). This rather limited focus on output and performance led to the development of more humanistic approaches to organizational management and philosophy.

The human relations movement resulted in organizations looking more closely at how they treated employees. Theorists began to seriously study factors such as human motivation, job satisfaction, morale, and work-group dynamics. "The chief concerns of the human relations movement were individuals, group process, interpersonal relations, leadership, and communications" (Marriner, 1979, p. 23).

Many managers have tried to incorporate human relations philosophy into their management style. Argyris (1971) points out the inherent conflict in philosophy that challenges managers--wanting to trust and believe in their fellow human beings, but not quite able to shake the fears that they won't prove trustworthy. Clearly, one's management style depends on clarification of personal values and philosophy (Marriner, 1979).

The behavioral science theories grew out of the business schools where theories of human motivation were applied to management

(Sashkin, 1981). Likert, who furthered the development of organizational thought using the behavioral science approach, stated "Every aspect of a firm's activities is determined by the competence, motivation, and general effectiveness of its human organization" (Likert, 1967, p. 1).

Organizations vary dramatically in size, management style and complexity, but all organizations have values that define their purpose; their reason for existance (Jones, 1981). These organizational values are reflected in the management philosophy. The organization cannot function smoothly without concensus on these values among the people in power (Jones, 1981).

Lewin (1952) studied work groups and their reactions to lack of goal or value clarity. He found that consistency in organizational values creates a secure environment for the member. If the goals or values are not clear, the result is anxiety. Lewin saw implications for individual adjustment of the members as well as work group relationships.

Argyris (1973) identified three values "endemic to the nature of pyramidal structures" (p. 64). They are:

> 1. The significant human relations are the ones which have to do with achieving the organization's objectives . . .
>
> 2. Cognitive rationality is to be emphasized; feelings and emotions are played down . . .
>
> 3. Human relationships are most effectively influenced through unilateral direction, coercion, and control, as well as by rewards and penalties that sanction all three characteristics (p. 64).

Argyris (1973) further points out that these values ultimately result in diminished interpersonal trust, openness, risk-taking and meaningful non-judgemental feedback.

Organizational members are more likely to internalize the organization's goals and values if they participate actively in decision-making; contribute significantly to the group; and have part of the reward for group accomplishment (Katz, 1970).

Trust

Argyris defines trust as: "That behavior that induces members to take risks, to experiment. The norm acts to influence the members to take risks, on the ideas and feelings levels." He further describes mistrust as: "That behavior that restricts and inhibits members from taking risks and experimenting. The norm acts to influence the members to disintegrate risk taking and experimenting" (Argyris, 1965, pp. 8-9).

Trust and a resulting willingness to take risks is necessary for interpersonal growth. A workgroup comprised of distrustful people, unwilling to take risks with each other, is a group with severely limited potential. "Groups, like other highly complicated organisms, need interaction, trust, communication, and commitment, and these ingredients require a period of gestation" (Bennis, 1968, p. 120).

Gibb (1972) supports the notion that trust is basic to the growth of individuals and groups. He links trust to the concepts of self-confidence, openness, self-realization and interdependence, in that none of these characteristics can be attained without first trusting oneself and others. He theorizes that trust is essential to successful organizational development, group and individual growth. Fear, on the opposite end of the fear-trust continuum, inhibits growth and learning (Gibb, 1978A). Management, therefore, must support, nurture

and encourage the growth of the work-group as a whole, and individuals in particular. They would accomplish this task by using management strategies based on trust and openness, and avoid using strategies that create fear and defensiveness (Gibb, 1972B). Gibb applies his theory to all levels of human interaction, from the workplace to the family (Gibb, 1978).

Gibb developed his theory out of personal observation and study. Because of his rather informal research style, there is no formal research testing his theory. There are, however, several studies dealing with interpersonal trust levels, or trust as a component of other concepts, such as interpersonal competence.

Friedlander (1970) used Gibb's model to study trust in relation to group accomplishment. He looked at two sets of groups, one with high levels of trust, initially, and one with low trust levels. One group participated in an organizational training laboratory and the other did not. He found that the group with the initial high trust level became a more productive, effective group after laboratory training. Conversely, the group with the low trust level remained less effective even after training. Further, trust seemed to act as a catalyst in encouraging group competence in groups that underwent training but this was not apparent in the groups that were not given training. He found that intragroup trust was the best predictor of group effectiveness and productivity after the training experience.

Kegan and Rubenstein (1973) studied trust in relation to individual and organizational effectiveness, and organizational development

programs. Their work supported their original hypothesis: 1) The greater a person's trust level with his/her work group, and the greater his/her general level of trust with all the people he/she comes into contact with in the process of working, "the greater will be his self-actualization" (p. 498); 2) A sound organizational development program has the effect of increasing a person's trust level in relation to their own work-group and others.

Argyris (1973) identified trust, risk-taking, and openness as components of interpersonal competence. In low-trust, high hear, bureaucratic organizations, risk-taking, openness, and trust are diminished, resulting in a closed system. Organizational members adapt to such a system by "playing it safe."

Argyris (1963) studied interpersonal competence in terms of problem solving and defensiveness. He looked at three types of organizations using a questionnaire, semi-structured interviews and observations as methods of measuring trust, openness and other components of interpersonal competence. He postulated that high competence was related to good problem solving ability and decreased defensiveness. In the three organizations studied, trust was almost non-existant and openness was low, according to their measurement tools. He speculated that if interpersonal difficulties of organizations worsen, over time output and technical activities will be diminished. He also predicts a lessening of innovation in organizations where there is decreased competence, a low trust level and little openness. Michael (1973) emphasizes the need for organizations to give support and encouragement for high interpersonal competence.

Trust, defined in a much broader context, is a component of the organizational climate; part of the "psychological atmosphere" created by organizational function (Jones, J., 1981, p. 160). Emery and Trist (1965) called this organizational environment "causal Texture." They described four types of environments. The fourth, "turbulent environment," is the one relevant to this discussion. Emery and Trist maintain that this is the environment that currently exists. It has "dynamic properties that arise not simply from the interaction of the systems, but also from the field itself. . . . These fields are so complex, so richly joined, that it is difficult to see how individual organizations can, by their own efforts, successfully adapt to them" (Emery, 1967, p. 223).

This environmental turbulence can have a dramatic effect on organizations and individuals, and yet the organization or individual often has little influence on the external environment. Most people depend on the external environment to support their internal sense of order and well-being. "To an important extent, organizational leadership typically has defined its competence by its ability to reduce or remove turbulence from the organizational setting, or, under conditions of its choice, to introduce it for special change-inducing purposes. One of the most powerful psychological rewards organizations provide their members is protection from turbulence . . ." (Michael, 1973, pp. 32-33).

Hopefully, organizations will at least be able to control the kinds of turbulence a member encounters, and where it comes from. Also, an organization can guide a member in coping by directing their assigned role performance. As turbulence increases, the ability of

an organization to cope diminishes. Michael (1973) defines coping with uncertainty as a primary problem facing complex organizations today.

Chapter II

METHODOLOGY

Research Design

The research design was correlational.

Setting

Two psychiatric units located in a 350-bed university hospital in Oregon provided the setting for this investigation.

Unit A

Unit A was a 14-bed "crisis unit," intended to provide short-term care to persons with acute psychiatric illness. The average length of stay on this unit was seven days. This unit provided care for patients held involuntarily pending a commitment hearing; patients incarcerated in county correctional facilities but needing psychiatric care; patients with legal charges pending who were identified at the time of arrest as needing psychiatric treatment; and people with acute psychiatric symptoms who sought care voluntarily through the university hospital emergency room. The patients incarcerated or with charges pending were provided a guard by the correctional facility to ensure that they remain in the hospital. The unit was considered a secure unit, in that specific attention was directed to keeping the environment safe for patients and staff, with the use of locked doors,

seclusion rooms and restraints as needed.

Any city-wide community attention given to psychiatric care was generally focused on Unit A, as it was informally considered to be a model of progressive psychiatric care.

The nursing management on Unit A had remained stable for many years, with a consistent head nurse whose management style was typically autocratic. The chaos created by the rapid turnover and largely involuntary status of the patients tended to attract rather aggressive, self-motivated nurses and psychiatric aides to the unit. Many of them were in transition, working and attending school. This contributed to a rapid staff turnover, as well. The environment was generally turbulent, with a great deal of rapid change and chaos. The staff consisted of registered nurses and psychiatric aides. The psychiatric aides on Unit A were classified at the third level of civil service classification, as opposed to Unit B aides, who were classified one step lower, at a two level. This resulted in higher pay for aides on Unit A, and created an obvious source of conflict between the two groups.

Unit B

Unit B had traditionally provided care for voluntary patients referred by their private physicians; patients voluntarily seeking care through the emergency room of the university hospital but needing longer-term care than Unit A provided; and patients from other areas of the state or surrounding states, with particularly interesting or unusual symptoms. The average length of stay on this unit was 14 days.

It had a bed capacity of 20. Unit B patients and staff often participated in research studies and piloted treatment modalities new to university hospital.

Unit B was considered a secure unit also, but generally less secure than Unit A in that there were fewer seclusion rooms. Traditionally severely agitated or violent patients were transferred to Unit A. Unit B was seldom the focus of public attention.

The nursing management of Unit B was in the process of rapid change. There had been a two to three year period of relative stability with a head nurse whose management style was predominantly laissez-faire This head nurse had been replaced at the insistence of the medical director, by a young, fairly inexperienced head nurse who chose a participative management style. At the time of the investigation, this head nurse had been in the role approximately ten months.

Unit B generally attracted passive, compliant staff who stayed for many years. Aside from the chaos surrounding the management changes, Unit B was commonly thought to be a less stressful, safer work environment. The unit characteristics are detailed in Table I.

Participants

The sample consisted of the entire nursing staff on both units. All staff were invited to participate. There were a total of 20 participants, including R.N.s, L.P.N.s and psychiatric aides. All were full-time staff, with varying levels of experience and education.

Table I

Unit Characteristics

	Unit A	Unit B
Management Style	Autocratic	Participative
Turbulence	High	Low
Patient Average Length of Stay	7 Days	14 Days
Staff Turnover	High	Low

Data Collection Instrument

The TORI Self-Diagnosis Scale, developed by Gibb (1978) (see appendix) was used to measure each participant's level of trust in themselves and others. TORI is an acronym for Trust, Openness, Realization and Interdependence. The instrument consists of 96 items. Forty-eight of the items are keyed to how the individual perceives herself in the group and 48 to how the individual perceives the group. The study participants ranked their agreement or disagreement using a four point scale ranging from strongly agree to strongly disagree.

The data collection instrument was used experimentally in this study to provide normative data. The validity and reliability of the instrument have not been established, but content validity is inferred.

Examples of items for each factor follow:

Trust (self)

1. I feel that no matter what I might do, this group would understand and accept me.

33. When I am in this group I feel very good about myself as a person.

65. I am an important member of this group.

Trust (group)

5. Members of this group trust each other very much.

37. Members seem to care very much for each other as individuals.

69. Members listen to the things I say in this group.

Openness (self)

26. I can trust this group with my most private and significant feelings and opinions.

58. In this group I feel free to be exactly who I am and never have to pretend I am something else.

90. I keep very few secrets from this group.

Openness (group)

30. In this group we really know each other well.

62. Group members listen to other members with understanding and empathy.

94. We don't keep secrets in here.

Realization (self)

3. I assert myself in this group.

35. It is easy for me to take risks in this group.

67. My goals are similar to the goals of the total group.

Realization (group)

7. The group exerts no pressures on the group members to do what they should be doing.

39. This group really lets people be where they are and who they are.

71. This group has a lot of energy.

Interdependence (self)

28. I look forward to getting together with this group.

60. I would miss anyone who left the group because each of the members is important to the group in what it is trying to do.

92. I feel a strong sense of belonging to this group.

Interdependence (group)

32. This group would be able to handle an emergency very well.

64. Group members listen to other members with understanding and empathy.

96. There is little destructive competition in this group.

Trust is seen by Gibb (1978) as the primary factor in determining a group's level of effectiveness and productivity. He identifies the four major components of trust as: trust, openness, realization and interdependence. When the trust level is high, group members behave in a "more personal, more open, more self-determining, and more independent" manner (Gibb, 1977, p. 73). Conversely, "when the trust level is low, members' behavior becomes more impersonal, closed, 'ought'-determined, and more dependent" (Gibb, 1977, p. 73). The TORI Scale is intended to measure the four components of trust, with scores on either end of the continuum reflecting the behaviors described above.

A high trust score indicates a person who has a well formed self-concept in relation to themselves and their role in the group. A low trust score implies a low sense of self-esteem.

Openness addresses a person's comfort level with self-revelation. A high scorer on the openness scale might see themselves and the group as open, and feel little need to hide or withold information. Alternately a low scorer would likely be someone who feels very vulnerable and exercises great caution in revealing themselves to the group.

The realization scale measures a group member's willingness to take risks, both personally and with the group.

Interdependence is a measure of a group members' sense of belonging with the group. A high scorer feels a strong sense of belonging and is able to work cooperatively with group members. A low scorer has a great deal of difficulty working effectively with the group, and is likely to feel dependent and competitive (Gibb, 1977).

Data Collection Procedure

Permission to conduct the investigation was obtained through the identified hospital channels. Participants were provided with a verbal and written explanation of the study. They signed a written consent form after reading and hearing it read. The instrument was administered to the participants in a group setting with no discussion during administration. The participants each chose a number at random from a list, and used that number on their consent and questionnaire forms. The consent forms were sealed in an envelope and returned separately from the research instrument so there was no way to identify who had completed which instrument. The participants were informed that their responses were confidential and would not be available to their employer. They were told to answer the questionnaire with their particular work-group in mind. The questionnaire included an attached demographic data sheet that identified the participant by number only (see appendix).

Data Analysis

The scores of each participant were computed to derive four "self" scores and four "group" scores. The difference of the means for each of the variables was calculated using a T-test to determine the significance of the difference. The level of significance was set at .05.

The range of scores for each scale is 0-36, with a score of 36 being on the positive end of the trust continuum, and 0 being on the negative end.

Chapter III

RESULTS AND DISCUSSION

In this chapter, the participants will be described, as well as the findings of the comparison studies. These findings will be discussed in relation to the specific groups involved in the comparisons.

Characteristics of the Participants

There were 30 invited participants. This comprised the entire nursing staff of both psychiatric units. Due to vacations, days off, and illness, 20 nursing staff were available to participate in the study; 9 from Unit A and 11 from Unit B. This was considered to be a representative number from each unit. The participants included registered nurses, licensed practical nurses and psychiatric aides. Characteristics of the participants are illustrated in Table II. The educational background of the psychiatric aide group varied considerably, since there is no clearly identified educational preparation for psychiatric aides. Unit A's policy was to hire psychiatric aides with at least a bachelor's degree, although there was no specification as to discipline studied. Unit B's policy was high school graduation as a basic preparation. The demographic data is similar for the two groups, with the main differences being in age and education. Unit B had a wider age range, and a higher mean age than Unit A. The educational background of staff on Unit A showed a

Table II

Characteristics of Participants

	Unit A	Unit B
Age		
Mean	28	32
Range	24-36	23-48
Classification		
RN	5	4
LPN	0	3
PA	4	4
Sex		
Male	4	3
Female	5	8
Education - Highest Level Completed		
High School	0	6
Associate Degree	2	1
Diploma/Nursing	1	1
Baccalaureate Degree	6	2
Masters Degree	0	1
Experience in Psychiatry at University Hospital		
5 Years or Less	6	7
Over 5 Years	3	4

greater number of staff with baccalaureate preparation than Unit B.

TORI Scores

Comparison of Unit A to Unit B

Mean scores for both units on the self and group items are presented in Table III. As can be seen, the mean scores are fairly close in range, with the overall highest mean scores (Range 10-33) from Unit A in self perception, and the overall lowest from Unit B in group perception (Range 11-23). The lowest in self and group mean scores are from Unit B on the openness items (Range 12-23). The highest group and self mean scores are from Unit A on the Trust and Interdependence items (Range 12-32). It is of interest ot note the wide range (10-33) of scores on the openness items for both self and group, of Unit A. The range might indicate a marked disagreement among participants from Unit A in regard to group and self openness. As can be seen in Table III the t-scores did not test out as significant with 18 degrees of freedom at the .05 alpha level.

Comparison of Self and Group Scores

As can be seen in Table IV, there was a significant difference in means at the .05 alpha level with 16 degrees of freedom on the Realization items. The self perception on the Realization items was significantly higher than the perception of the group.

Gibb (1978, p. 315) sees a high self score on the Realization items as a person who views themselves as assertive, willing to take risks, and free to do whatever they really wish to do. A low group score

Table III

Comparison by Unit

Mean Scores

	Trust	Openness	Realization	Inter-Dependence
Unit A N = 9				
Self	23.44	18.78	22.67	24.78
Range	17 - 27	10 - 30	15 - 31	16 - 32
Group	21.22	19.89	18.22	20.11
Range	17 - 26	8 - 33	14 - 24	12 - 29
Unit B N = 11				
Self	19.90	16.82	18.91	21.00
Range	13 - 30	13 - 23	13 - 25	14 - 29
Group	19.09	16.73	16.64	17.73
Range	13 - 22	12 - 23	12 - 21	11 - 23
T Score				
Self	1.58	.86	2.06	1.83
Group	1.55	1.34	.74	.90

Table IV

Comparison of Self and Group

Mean Scores

	Trust	Openness	Realization	Inter-Dependence
Unit A N = 9				
Self	23.44	18.78	22.67	24.78
Range	17 - 27	10 - 30	15 - 31	16 - 32
Group	21.22	19.89	18.22	20.11
Range	17 - 26	8-33	14 - 24	15 - 29
T Score	1.26	.33	*2.37	1.89
Unit B N = 11				
Self	19.90	16.82	18.91	21.00
Range	13 - 30	12 - 23	13 - 25	14 - 29
Group	19.09	16.73	16.64	17.73
Range	13 - 22	12 - 23	12 - 21	11 - 23
T Score	.62	1.62	1.57	1.66

*Significant at the .05 Alpha Level

on the Realization items describes a view of the group that includes seeing group members as applying a great deal of pressure on members to conform and to work toward group goals that are insignificant to that group member.

This finding fits with the picture of Unit A staff as described in earlier chapters. Most of the staff see their position on Unit A as temporary; a means by which to achieve an unrelated goal. The staff turnover rate is high and many staff are attending school as well as working. The Unit B staff has historically worn the reputation of an independent, unconventional group that seem to relish group conflict.

Also, the Openness scores for Unit A show a rather remarkable range, indicating, again, some disagreement on the part of participants as to the degree of Openness on Unit A.

Comparison of Registered Nurses to Psychiatric Aides

Mean scores for registered nurses and psychiatric aides are presented in Table V. As can be seen, there was a significant difference in the means of two groups of items. First, the means for the self Interdependence items were significantly different for registered nurses than for psychiatric aides, at the .05 alpha level with 15 degrees of freedom. The psychiatric aide group viewed themselves in relation to Interdependence, lower than the registered nurse group.

According to Gibb (1978, p. 307) a participant who scores low on this set of items might be indicating they do not feel a sense of group cohesion, or it might reflect competitive feelings that interfere with their ability to work as a group. This finding might be explained

Table V

Comparison of Registered Nurse and

Psychiatric Aide Mean Scores

	Trust	Openness	Realization	Inter-Dependence
Self				
RN	23.56	19.78	21.67	25.67
Range	18 - 30	13 - 30	13 - 31	17 - 32
PA	19.50	15.25	19.50	19.62
Range	13 - 26	10 - 25	15 - 27	14 - 27
T Score	1.04	1.92	.89	*2.69
Group				
RN	21.33	19.22	18.33	20.78
Range	19 - 26	12 - 33	16 - 24	12 - 29
PA	18.13	17.00	16.00	16.50
Range	16 - 25	8 - 23	12 - 21	11 - 23
T Score	*2.34	.81	1.62	1.75

* Significant at the .05 alpha level

N = 9 RNs

N = 8 PAs

N = 17 total

in view of the historical role of psychiatric aides in this institution. As a very small group in a large organization, psychiatric aides have at times felt the need to defend their positions, as Primary Nursing and other professional nursing programs have caused the nursing administration to question the validity of a psychiatric aide role. This turmoil was present at the time of this study.

The second significant score was group Trust. There was a significant difference at the .05 alpha level in the means of the registered nurse and psychiatric aide groups, with the psychiatric aides mean score significantly lower than the registered nurses. Again, the reason may be role conflict with the registered nurse group clearly more aligned with nursing administration than the psychiatric aide group. A low score on the trust items for the group may indicate a personal view that includes seeing the group as untrustworthy and feeling defensive and threatened by the group (Gibb, 1978, p. 306).

It is of interest that the psychiatric aide group quite consistently scored lower on all the items than the registered nurse group, although the difference was not significant on all items. The lowest score obtained from any participant was a score of 8 by a psychiatric aide on the group Openness set of items. The highest score was 33 on the group Openness set of items by a registered nurse.

Comparison by Length of Experience

Mean scores were compared by the participant's length of experience in the institution. Five years, more or less, was chosen as the sorting number, as the participants naturally grouped around that number, as can

be seen in Table VI. There was no significant difference in the means of those participants with over 5 years experience compared to those with less than 5 years experience. The rapidly changing nature of hospitals as organizations undoubtedly makes it difficult to form the kind of trusting, predictable relationships that people in slowly changing, more stable organizations might experience, so that length of experience in a hospital might not result in increasing Trust, Openness, Realization and Interdependence.

Comparison by Age

Mean scores of participants aged 20-30 were compared to participants aged 32+. These scores are represented in Table VII. There was no significant difference in the means on any of the sets of items for the self or group scales. Clearly, age did not significantly influence the outcomes on the four factors of Trust, Openness, Realization, and Interdependence. One might speculate that age, as representative of more life experience, would effect an increase in the mean score of the self scale, but this data did not support that speculation.

Table VI

Comparison of Mean Scores by Length of Experience

	Trust	Openness	Realization	Inter-Dependence
Self				
↑5 yrs Experience	21.71	18.42	21.14	22.71
Range	16 - 26	12 - 25	17 - 27	17 - 26
↓5 yrs Experience	81.38	17.31	20.31	22.69
Range	13 - 27	13 - 30	13 - 31	14 - 32
T Score	.15	.46	.37	.008
Group				
↑5 yrs Experience	21.29	18.57	18.14	18.87
Range	19 - 25	12 - 23	16 - 21	16 - 23
↓5 yrs Experience	19.38	17.92	16.92	18.77
Range	13 - 26	8 - 33	12 - 24	12 - 29
T Score	1.39	.32	.73	.02

N = 7 ↑5 yrs Experience

N = 13 ↓5 yrs Experience

N = 20 Total

Table VII

Comparison of Mean Scores by Age of Participant

	Trust	Openness	Realization	Inter-Dependence
Self				
↑31	21.29	16.86	20.43	21.86
Range	16 - 26	12 - 25	15 - 27	16 - 27
↓31	21.62	18.15	20.69	23.15
Range	13 - 30	13 - 30	13 - 31	14 - 30
T Score	.15	.54	.12	.53
Group				
↑31	21.14	17.29	17.86	18.00
Range	18 - 25	8 - 23	14 - 21	12 - 23
↓31	19.54	18.62	17.08	19.23
Range	13 - 26	14 - 33	12 - 24	12 - 28
T Score	1.32	.52	.54	.52

N = 7 ↑31

N = 13 ↓31

N = 20 Total

Chapter IV

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

The characteristics of a health care organization's interpersonal work environment are crucial to quality patient care, staff job satisfaction and ultimately the organization's ability to successfully attain its goals. As organizational turbulence increases with changing nursing roles, rapid technical advances and new models of patient care, the interpersonal work environment becomes increasingly more important in its role of providing a fairly stable climate in which a professional nurse can grow. Trust is a characteristic that is basic to interpersonal work-group relationships. The lack of trust can lead to strained interpersonal relationships and ultimately, though communication break-down, to unsafe nursing practice. Few studies have addressed the interpersonal work environment. There are no studies known to this author that address the hospital interpersonal work environment.

In this study, two work groups were described in terms of four characteristics: trust, openness, realization and interdependence. The purpose was to produce descriptive data on which a further, more detailed description of the hospital's interpersonal work environment could be built.

Conclusions

Three findings attained statistical significance at the .05 alpha level. They were: 1) Unit A's scores on the self realization item was significantly higher than on the realization item; 2) the registered nurse group scored significantly higher than the psychiatric aide group on the self interdependence items; 3) the registered nurse group scored significantly higher than the psychiatric aide group on the group trust items.

It is of interest to note the remarkably wide range of scores on the openness items for Unit A, indicating a marked difference in perceptions of the participants from Unit A. Also of interest, is the scoring pattern with the psychiatric aides consistently scoring lower on all items than the registered nurse group. It can be speculated that role conflict between the psychiatric aide and registered nurse groups contributed in large part to the findings of this study. It can be further speculated that until there is some resolution of this conflict, the interpersonal work environment will continue to reflect a decrease in trust, openness, realization and interdependence for the politically less powerful psychiatric aide group.

Clearly, further research looking at the interpersonal work environment is needed before generalizable conclusions can be reached.

Recommendations

The findings of this investigation suggest several possibilities for further study.

First, the study could be replicated using a larger, more heterogeneous sample. This might serve to clarify the findings by producing a broader score distribution.

Second, it would be of value to investigate further the relationship between group stability, environmental turbulence, management style and TORI scores using a tool to measure these variables.

Third, there are several groups that would provide logical comparison possibilities. Among them, private compared to public organizations, team nursing compared to primary nursing; participative management organizations compared to traditional management organizations; nurses compared by organizational levels; nurse educators compared to nurses in clinical practice and nursing management groups compared to staff nurses. These comparisons would undoubtedly result in a good deal of descriptive data that could add to a picture of the nurses' interpersonal work environment.

Fourth, in the process of further validating the TORI tool, it might be of value to compare personality variables with TORI scores, using a tool that measures personality characteristics, such as the Minnesota Multiphasic Personality Inventory.

The Fifth recommendation for further investigation would be a longitudinal study using a large sample from the same organization with internal variables such as program changes, budgetary fluctuations and leadership styles taken into account.

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APPENDIX A

Informed Consent Form

INFORMED CONSENT FORM

I, ______________________________, agree to serve as a subject in the clinical investigation of Jenelle Fleck, B.S., R.N., concerning the level of trust in the organization under the supervision of Marie Berger, M.S., R.N..

I understand that my part in the investigation will be to answer the questions on the "TORI Group Self-Diagnosis Scale" as honestly and candidly as possible. I understand that I will answer the questions from my perspective as a staff member on 5A/PCU, as it was previous to the merger. I also understand that the purpose of this study is to look at the two staff groups separately and not to look at individual staff members. The information will remain confidential and I will not be identified by name to the investigator.

Jenelle Fleck is available to answer any questions I might have concerning my participation in the study. I understand my participation is voluntary and I may choose not to participate.

I have read the preceding and agree to participate in this study.

Date________________________ Subject ______________________________

Witness ______________________________

APPENDIX B

TORI Scale

TORI GROUP SELF-DIAGNOSIS SCALE
Jack R. Gibb

Instructions: In front of each of the following items, place the letter that corresponds to your degree of agreement or disagreement with that statement.

SD = strongly disagree D = disagree A = agree SA = strongly agree

_____ 1. I feel that no matter what I might do, this group would understand and accept me.

_____ 2. I feel that there are large areas of me that I don't share with this group.

_____ 3. I assert myself in this group.

_____ 4. I seldom seek help from this group.

_____ 5. Members of this group trust each other very much.

_____ 6. Members of this group are not really interested in what others have to say.

_____ 7. The group exerts no pressures on the group members to do what they should be doing.

_____ 8. Everyone in this group does his own thing with little thought for others.

_____ 9. I feel that I have been very cautious in this group.

_____ 10. I feel little need to cover up things when I am in this group.

_____ 11. I do only what I am supposed to do in this group.

_____ 12. I find that everyone in this group is willing to help me when I want help or ask for it.

_____ 13. The members of the group are more interested in getting something done than in caring for each other as individuals.

_____ 14. Members of this group tell it like it is.

_____ 15. Members do what they ought to do in this group, out of a sense of responsibility to the group.

_____ 16. This group really "has it together" at a deep level.

_____ 17. I trust the members of this group.

_____ 18. I am afraid that if I showed my real innermost thoughts in this group, people would be shocked.

_____ 19. In this group, I feel free to do what I want to do.

_____ 20. I often feel that I am a minority in this group.

_____ 21. People in this group seem to know who they are; they have a real sense of being individuals.

_____ 22. Group members are very careful to express only relevant ideas about the group's task or goal.

_____ 23. The goals of this group are clear to everyone in the group.

_____ 24. The group finds it difficult to get together and do something it has decided to do.

_____ 25. If I left this group, the members would miss me very little.

_____ 26. I can trust this group with my most private and significant feelings and opinions.

_____ 27. I find that my goals are different from the goals of this group.

_____ 28. I look forward to getting together with this group.

_____ 29. People are playing roles in this group and not being themselves.

_____ 30. In this group we really know each other well.

_____ 31. This group puts pressure on each member to work toward group goals.

_____ 32. This group would be able to handle an emergency very well.

_____ 33. When I am in this group I feel very good about myself as a person.

_____ 34. If I have negative feelings in this group, I do not express them easily.

_____ 35. It is easy for me to take risks in this group.

_____ 36. I often go along with the group simply because I feel a sense of obligation to it.

_____ 37. Members seem to care very much for each other as individuals.

_____ 38. Members often express different feelings and opinions outside the group than they express inside.

_____ 39. This group really lets people be where they are and who they are.

_____ 40. Members of this group like either to lead or to be led, rather than to work together with others as equals.

_____ 41. My relationship to this group is a very impersonal one.

_____ 42. Whenever I feel strongly about something in this group I feel easy about expressing it.

_____ 43. I feel that I have to keep myself under wraps in here.

_____ 44. I enjoy working with members of this group.

_____ 45. Each member of the group seems to play a definite and clear role and is respected on the basis of how well he performs that role.

_____ 46. Whenever there are negative feelings in this group, they are likely to be expressed at some point.

_____ 47. At times the members seem very apathetic and passive.

_____ 48. As a group we are well integrated at many levels.

_____ 49. I feel like a unique person in this group.

_____ 50. I would feel very vulnerable if I told this group my most secret and private feelings and opinions.

_____ 51. The group feels that my personal growth is important.

_____ 52. I don't often feel like cooperating with others in this group.

_____ 53. Group members have a high opinion of my contributions to the group.

_____ 54. Members of the group are afraid to be open and honest with the group.

_____ 55. When decisions are being made, members quickly express what they want.

_____ 56. People in this group are individuals and do not work together as members of a team.

_____ 57. I don't feel very good about myself in here.

_____ 58. In this group I feel free to be exactly who I am and never have to pretend I am something else.

_____ 59. It is very important that I meet others' expectations in this group.

_____ 60. I would miss anyone who left the group because each of the members is important to the group in what it is trying to do.

_____ 61. It is easy to tell who the "in" people are in this group.

_____ 62. Group members listen to other members with understanding and empathy.

_____ 63. The group spends a lot of energy trying to get members to do things they don't really want to do.

_____ 64. Group members enjoy being with each other.

_____ 65. I am an important member of this group.

_____ 66. My ideas and opinions are distorted by the group.

_____ 67. My goals are similar to the goals of the total group.

_____ 68. Group members seldom give me help on the things that really matter to me.

_____ 69. Members listen to the things I say in this group.

_____ 70. In here, if people feel negative they keep it to themselves.

_____ 71. This group has a lot of energy that gets directed into whatever we do.

_____ 72. You really have to have some power if you want to get anything done in this group.

_____ 73. I don't feel very genuine and real in this group.

_____ 74. There is hardly anything I don't know about the members of this group.

_____ 75. If I did what I wanted to do in this group, I would be doing different things from what I am now doing.

_____ 76. I am aware of the ways that the group members help me in what I am trying to do.

_____ 77. Some members are afraid of the group.

_____ 78. The members of this group are very spontaneous and uninhibited when they are around each other.

_____ 79. The goals of this group are often not really clear.

_____ 80. This group works together as a smoothly functioning team.

_____ 81. I care very much for the people in this group.

_____ 82. The group misunderstands me and how I feel.

_____ 83. When we reach a decision about a goal I am usually in complete agreement with the goal.

_____ 84. I have no real sense of belonging to this group.

_____ 85. The group treats each person in the group as an important member.

_____ 86. It is easy to express feelings in here if they are positive, but not if they are negative.

_____ 87. Members of this group are growing and changing all the time.

_____ 88. We need a lot of controls in here to keep the group on track.

_____ 89. I often feel defensive in here.

_____ 90. I keep very few secrets from this group.

_____ 91. It is not OK to be myself in this group.

_____ 92. I feel a strong sense of belonging to this group.

_____ 93. It is easy to tell who the important members of this group are.

_____ 94. We don't keep secrets in here.

_____ 95. A lot of our energy goes into irrelevant and unimportant things.

_____ 96. There is little destructive competition in this group.

APPENDIX C

Demographic Data Sheet

Research Participant Number ________

Demographic Data Sheet

Please fill out this form and return it with your TORI Scale.
All answers are confidential.

Please circle answer:

Sex:

Male Female

Age:

20-30 31-40 41-50

Highest Level of Education Completed:

High School Baccalaureate Degree

Associate Degree Masters Degree

Diploma/Nursing

Number of Years Experience in this Institution

0-5 6-10 11-20

AN ABSTRACT OF THE CLINICAL INVESTIGATION OF

JENELLE FLECK

For the MASTER OF NURSING

Date of Receiving this Degree: June 11, 1982

Title: TRUST IN ORGANIZATIONS

Approved:
Marie Berger, Advisor

The sample consisted of 20 nursing staff members including nine registered nurses, three licensed practical nurses, and eight psychiatric aides, from two psychiatric inpatient units in a 350 bed university hospital.

The TORI Group Self-Diagnosis Scale was administered to the subjects in an attempt to measure four aspects of trust, including trust, openness, realization and interdependence. The TORI Scale measured both self perception and perception of the group in terms of the four components of trust. The TORI Scale included 96 items yielding eight scores: four related to self perception of trust, openness, realization and interdependence, and four related to group perception of trust, openness, realization and interdependence. The participatns rated the items on a four point scale from strongly agree to strongly disagree. Demographic data was obtained through a questionnaire asking for characteristics such as sex, age, educational level, and length of experience.

The means were compared Unit A to Unit B, self to group scores for each unit, registered nurses to aides, by length of experience and age of participants. A comparison of the means indicated three statistically significant findings. First, Unit A scores for self realization were significantly higher than Unit A scores for group realization. The second significant difference in means was between the registered nurses view of self interdependence and the psychiatric aides perception of self interdependence. The RN group viewed self interdependence higher than the PA group. Third, the registered nurses perception of group trust was significantly higher than the psychiatric aides view of group trust. Also of interest was the wide score range on the openness scale.

Applicability for nursing was discussed and recommendations outlined for further study.