Importance of role clarity: a critique of the literature

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Kay Mafuba and colleagues argue that, for community learning disability nurses, an understanding of the concept of 'role' is indispensable

Correspondence
kay.mafuba@uwl.ac.uk

Kay Mafuba is associate professor at the University of West London's College of Nursing Midwifery and Healthcare, Brentford, Middlesex

Dorothy Kupara is lecturer – learning disabilities, University of West London's College of Nursing Midwifery and Healthcare

Maria Cozens is lecturer – learning disabilities, University of West London's College of Nursing Midwifery and Healthcare

Chiedza Kudita is public involvement co-ordinator, University of West London's College of Nursing Midwifery and Healthcare

Date of submission
May 1 2015

Date of acceptance
June 4 2015

Peer review
This article has been subject to double-bind review and has been checked using antiplagiarism software

Author guidelines
journals.rcni.com/r/ldp-author-guidelines

Abstract

Community learning disability nurses need a clear understanding of the concept of 'role'. This is important because it has implications for role clarity, role perception and role enactment when meeting the healthcare needs of people with learning disabilities. In addition, understanding of 'role' prevents role ambiguity and role conflict in the work environment, and can help to ensure appropriate delivery of health care to people with learning disabilities, who often present with complex needs. This article examines literature on role from symbolic interactionist, psychological, anthropological and organisational role-theory perspectives. It also highlights the significance of role ambiguity and examines current role-theory research in community learning disability nursing.

Keywords
learning disabilities, learning disability nurse, role ambiguity, role enactment, role perception, role taking

THIS ARTICLE explores the importance of the concept of role and evaluates its significance in how community learning disability nurses (CLDNs) enact their roles. It highlights existing evidence in nursing practice that has significance for the ways in which CLDNs meet the complex healthcare needs of people with learning disabilities.

The word 'role' and its use originated in the French language (Thomas and Biddle 1966a). Banton (1965) describes role as a position occupied by an individual. This definition implies that role can only be understood as a social process involving interactions and expectations of an individual and how their role is set. CLDNs' understanding of the concept of role has implications for how they carry out their roles in meeting the healthcare needs of people with learning disabilities.

Symbolic interactionist perspective

Mead's (1934) work explored the concepts of 'self', 'interaction' and 'socialisation', which are useful for CLDNs' understanding of their roles: the concept of self is important for reflexive practice; CLDNs need to interact with other professionals and influence inter-agency boundaries; and socialisation is important for CLDNs as they need to adapt to continuously changing roles. Mead's concept of 'role taking' is important for CLDNs as it describes how roles are perceived and understood. Coutu (1951) defined 'role taking' as a theoretical distinction between one's own role and the overt enactment of a role that would be considered to be of another. Conway (1988) defines role taking as 'the reflection of an understanding of the generalised attitudes of others in one's actions'. The notion of reflexivity inherent in this approach to role taking is important in understanding how CLDNs enact their roles. Also important is that this definition suggests role taking has much to do with how an individual views how others evaluate their roles as the way that roles are perceived and understood will influence 'role taking'.

Understanding how CLDNs carry out their roles where role conflict exists will add invaluable knowledge to CLDNs' practice. The roles of CLDNs transcend professional and interagency boundaries. In a recent study Mafuba (2013) reported that in such a working environment philosophical and

agency tensions arise and moderate how CLDNs undertake their roles.

Another useful observation made by Mesler (1991) is the failure of role-encroachment and boundary-encroachment literature to sufficiently account for occupational interactions and their impact on role enactment. Given these observations, it is not unreasonable to conclude that the presence or absence of role clarity is not sufficient in explaining how CLDNs enact their roles.

Psychological perspective

Jacob Moreno's (1960) contributions to role theory that are relevant to CLDNs' practice are the ideas that the formation of roles progresses mainly through two stages: role perception and role enactment. There are limited recent studies of how CLDNs perceive and enact their roles (Boarder 2002, Mafuba and Gates 2013, Mafuba 2013).

The exploratory study by Boarder (2002) of the perceptions of CLDNs of their roles and ways of working partially explored some public-health roles undertaken by CLDNs. Mafuba (2013) and Mafuba and Gates (2013) have detailed the roles of CLDNs and described influences on how nurses enact those roles, explaining how relationships have an effect on how they perceive and carry out those roles.

Role enactment is also referred to as role behaviour (Newcomb 1950), role performance and role interpretation (Fondas and Stewart 1994). The use of such a wide range of terminology referring to the same concept may be confusing and unhelpful. It is evident from the literature that perceptions of the concept have a direct impact on how successfully an individual enacts a prescribed role.

In this review, role enactment refers to how CLDNs carry out their roles. In a study of role and role enactment by nurses and doctors, Scott (1995) concluded that the quality of nurses' enactment of their clinical roles affected patient care. This is of particular significance to CLDN practice because it suggests that how CLDNs perceive their roles will directly affect the way that people with learning disabilities experience access to health services.

In an analysis of role enactment by nurses in acute care settings, Squires (2004) concluded that the process of role enactment is multidimensional. Autonomy is important for successful role enactment (Irvine-Doran *et al* 2002) so how CLDNs enact their roles may be influenced by the degree of autonomy they possess. In addition, Squires (2004) cites studies demonstrating that role clarity is another important dimension in how nurses enact their roles.

Anthropological perspective

Linton (1936) suggests that roles are dynamic representations of positions that individuals occupy. On the other hand, he describes role as a status or position or a collection of duties. Linton's main point is that individuals enact their roles when they perform their duties. This is important in community learning disability nursing practice and there is need for research that explores the clarity of learning disability nurses' 'duties' in job descriptions or role specifications.

What emerges from the literature is an extensive adjectival use of the word 'role'. These different uses have led to interpretations of 'role', which in turn has led to considerable ambiguity and confusion about how role should be defined (Banton 1965). This could help explain why many CLDNs find it difficult to articulate what their role is, resulting in them often undertaking what could be perceived as non-nursing tasks. The first attempt at collating the definitions of role as a concept can be traced to Thomas and Biddle (1966b), who identified three commonly used definitions of 'role' in role theory.

Organisational perspective

Organisational role theory addresses how individuals accept and enact their roles in task-oriented hierarchical organisations such as the NHS (Biddle 1986, Madsen 2002). For CLDNs, roles in such organisations are associated with employment positions and normative expectations. Of even more interest perhaps is our understanding of how individuals enact their roles when expectations are ambiguous to the individual and the organisation. It is expected that employees 'take' the role that is defined by their employer when they accept an employment position (Katz and Kahn 1978). What is not clear from previous role-theory studies, and which needs further investigation, is how lack of role clarity affects the way CLDNs interpret and enact their roles.

Role ambiguity

According to Kahn *et al* (1964) and Beehr (1976), role ambiguity refers to the lack of specificity and predictability for an individual employee's job or role functions and responsibilities. Lack of clarity in terms of role expectations is likely to lead to role ambiguity.

According to Kahn *et al* (1964), role ambiguity results in role conflict, role stress and role overload. In addition, Rizzo *et al* (1970) and Singh (1998) demonstrate that role ambiguity is negatively correlated with how individuals enact their

occupational roles. However, in some situations individuals would consider role ambiguity as an opportunity to be exploited, while for others it will be a source of conflict, frustration and stress (Willcocks 1994). It is therefore important for CLDNs to be aware of how they may react to role ambiguity.

Role ambiguity in nursing is rooted in the dialogical and practice ambiguity of the concept of nursing itself (Gagan 2002). Rungapadiachy *et al* (2006), in a study of how newly qualified mental health nurses perceived their nursing roles, concluded that the role of the mental health nurse is ambiguous because of the wide variety of tasks it entails. This view has significance for newly qualified CLDNs. Pryor (2007) identified lack of role preparation, heterogeneity of the role set and poorly articulated job roles as significant contributors to role ambiguity. In addition, CLDNs find themselves working in organisations where the priority is not necessarily the implementation of health policy for people with learning disabilities (Mafuba 2013). In separate studies, Tarrant and Sabo (2010) and Gormley and Kennerly (2011) observed strong negative correlations between role ambiguity and role conflict.

In addition, Tunc and Kutanis (2009) noted strong positive correlations between role conflict and role ambiguity and burnout. These conclusions have implications for how CLDNs are involved in implementing health policy for people with learning disabilities.

Role theory research

There is a rich history of studying nurse roles in general but not with respect to CLDNs' health policy implementation roles. A few examples of extensive

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studies exist – for example, of community nursing roles (Mobbs *et al* 2002), the advocacy role (Llewellyn 2005) and public health roles (Mafuba 2013, Mafuba and Gates 2013). A lack of in-depth research evidence evaluating and validating the role of CLDNs needs to be addressed to demonstrate positive contributions to how health policy is implemented for people with learning disabilities.

Perhaps of greater concern in the current literature is the lack of role clarity among learning disability nurses themselves, other health professionals and in primary care organisations (Mobbs *et al* 2002). Studies have shown that lack of role clarity presents a challenging and significant impediment to the successful implementation of health policy (Fyson 2002). Taylor (1996) has noted that lack of role clarity and confused and ambiguous expectations of and between healthcare professionals result in reduced quality of care. By contrast, clarity of role expectation is beneficial in improving communication, flexibility and responsiveness at every level of healthcare policy implementation (Taylor 1996).

Conclusion

There are significant gaps in knowledge in role theory regarding our understanding of how community learning disability nurses enact their roles in the implementation of health policy for people with learning disabilities.

It is vital to gain understanding in this area to ascertain the effect of these gaps on the implementation of health policy for people with learning disabilities. Further research is necessary to explore how health policy is translated into the roles of CLDNs.

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Conflict of interest
None declared

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