Nursing empowerment  
by Jill Banning Ripley  

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Nursing  
Montana State University  
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Abstract:  
The concept of empowerment has been applied to nursing recently, but nurses have been identified as powerless by several authors. Empowerment can be personal or social (organizational). The purpose of this study was to determine if relationships existed between personal and organizational empowerment scores and the variables of rurality of practice, age, gender, educational level, frequency of exercise, and practice autonomy. The ultimate goal of the research was to assist nurses to refine their concepts of empowerment as it relates to nursing.  

The research assessed the scores of Montana nurses on personal and organizational empowerment scales; and identified potential relationships between those scores and rurality of practice, age, gender, education, frequency of exercise, and autonomy of practice. Other variables found in the literature and analyzed for potential relationships with empowerment were: organizational level, full-time vs. part-time employment, autonomous roles, and participation in shared governance.  

Personal empowerment was measured using the Montana Empowerment Scale (MES), and organizational empowerment using Chandler's Instrument. Two hundred actively-practicing Montana registered nurses were surveyed by mail during the summer of 1993. Response rate was 39.5% (N=79). Data were analyzed using correlations and analysis of variance (ANOVA).  

Results showed no significant differences between or within variables and scoring on the MES. With Chandler's Instrument, significant differences were found which showed that organizational empowerment is related to increased age, higher education, increased responsibility, increased autonomy and participation in shared governance.  

Although rural and urban nurses differed in age, education, exercise habits, and employment status, they did not differ in feelings of autonomy or in empowerment scores. Implications exist for the empowerment of nurses through education and employment culture changes in rural states such as Montana.
NURSING EMPOWERMENT

by

Jill Banning Ripley

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Nursing

MONTANA STATE UNIVERSITY
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December, 1994
APPROVAL

of a thesis submitted by

Jill Banning Ripley

This thesis has been read by each member of the thesis committee and has been found to be satisfactory regarding content, English usage, format, citations, bibliographic style, and consistency, and is ready for submission to the College of Graduate Studies.

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Date  12 March, 1995
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The concept of empowerment has been applied to nursing recently, but nurses have been identified as powerless by several authors. Empowerment can be personal or social (organizational). The purpose of this study was to determine if relationships existed between personal and organizational empowerment scores and the variables of rurality of practice, age, gender, educational level, frequency of exercise, and practice autonomy. The ultimate goal of the research was to assist nurses to refine their concepts of empowerment as it relates to nursing.

The research assessed the scores of Montana nurses on personal and organizational empowerment scales; and identified potential relationships between those scores and rurality of practice, age, gender, education, frequency of exercise, and autonomy of practice. Other variables found in the literature and analyzed for potential relationships with empowerment were: organizational level, full-time vs. part-time employment, autonomous roles, and participation in shared governance.

Personal empowerment was measured using the Montana Empowerment Scale (MES), and organizational empowerment using Chandler's Instrument. Two hundred actively-practicing Montana registered nurses were surveyed by mail during the summer of 1993. Response rate was 39.5% (N=79). Data were analyzed using correlations and analysis of variance (ANOVA).

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Although rural and urban nurses differed in age, education, exercise habits, and employment status, they did not differ in feelings of autonomy or in empowerment scores. Implications exist for the empowerment of nurses through education and employment culture changes in rural states such as Montana.
CHAPTER 1

INTRODUCTION

The concept of empowerment is not new to the science of management, but has been applied to nursing recently. Webster defines the word "empower" as "to give power or authority to; to authorize; to give ability to; to enable" (Webster, 1983, p. 595). The word "power" is defined as "the ability to do, capacity to act; capability of performing or producing" (p. 1412). Nurses are being urged to empower their clients (Nicholson & Matross, 1989), their communities (McElmurray et al, 1990), and their profession (Trofino, 1989; Schaefer, 1990). But nurses have also been identified as powerless by Benner (1984) and Martin (1990). One cannot confer power one does not possess (Dobos, 1990), and yet little research has been done which assists nurses to empower themselves.

Literature on the subject generally falls into two categories - personal and organizational empowerment. Many authors define empowerment in terms of personality attributes, others as an organizational process or function. Many see empowerment as measured by motivation and achievement; others as a product of motivation. There are many definitions but little empirical data on factors influencing the identification, process, or outcome of empowerment. A
A comprehensive discussion of current thought regarding empowerment is given in Chapter 2.

Rurality of practice is important to the study because rural nurses have been shown to score lower on self-actualization scales by St. Clair, Pickard & Harlow (1986), and may be at risk for powerlessness. Age is important because of a possible link to self-actualization, a component of empowerment (St. Clair et al., 1986). Gender is also important because nursing has traditionally been a "female" profession, and has historically been under the authority of medicine, a "male" profession. Cultural expectations play a great part in the freedom of expression exercised in a profession and therefore, the degree of satisfaction obtained from it. Education is important because knowledge and power have been linked (Bartlett, 1980). Frequency of exercise is selected because exercise plays a part in self-esteem and therefore becomes another component of personal power. Autonomy of practice is selected because autonomous roles provide opportunity for creativity and reinforcement of self-efficacy, and therefore empowerment (Conger & Kanungo, 1988). Taken together, the variables identified represent the structure of the concept of personal empowerment.
Purpose

The purpose of this research is to assess outcomes of Montana nurses on organizational and personal empowerment scales, and to identify associations between those empowerment scores and the variables of rurality of practice, age, gender, education, frequency of exercise, and autonomy of practice. This is accomplished by exploring current literature regarding the concept, testing for association between the variables listed above and scores on empowerment-measuring instruments, critically analyzing the results, making conclusions, and communicating the results. The ultimate goal of this research is to assist nurses to refine their concepts of empowerment as it relates to nursing.

Background and Significance

Professional nursing is one of the largest of the female-dominated professions. However, nursing has been slow to unite to improve its professional reimbursement in comparison with similar professions (Brider, 1990), reward or promote members for educational achievement (AJN, 1990), or increase leverage in the hospital or in the sociopolitical environment (Styles, 1990). Many nurses require permission from physicians and administrators to use the judgement for which they are educated. They are frequently
"disciplined" for risk-taking and whistle-blowing (Anderson, 1990). In the last two hundred years, nursing has made much progress in increasing pay from poverty-level to adequate salary. Nurses no longer empty the coal bucket and scrub the floors in most places. However, they still score very low on structural power assessments (Chandler, 1991). It is no coincidence that "empowerment" is one of the most frequently used buzzwords in nursing today.

There are approximately 1.75 million active registered nurses in the United States (U.S. Bureau of the Census [USBC], 1991). Sixty-seven per cent are currently employed by hospitals, and 97% are female (USBC, 1991). Registered nurses are the principal caregivers for the sick and injured, amounting to 862,500 patients per day (USBC, 1991). Nurses see and care for persons at their most vulnerable and powerless moments. Yet many nurses feel they have little or no control over their salaries, schedules, or professional futures. Nurses describe problems related to domination by administrators and physicians who collect for their nursing services (Griffith, Thomas & Griffith, 1991), victimization by bureaucratic and authoritarian management styles (Corwin & Taves, 1962), and coercion to assume responsibility for the actions of undertrained persons whose innocent mistakes could jeopardize their careers (Gardner, 1991). Domination, victimization, and coercion are identified as
conditions of powerlessness by Kanter (1979), and are not suffered exclusively by nurses, but by women in general.

Nurses are indispensable members of the health care delivery team. They assess patients' conditions, plan their care, intervene to optimize outcomes, and evaluate their results. They assist physicians, supervise other workers, and contribute toward a health organization's accreditation. They comprise the greatest portion of the hospital work force. Women are socialized to be relationally-oriented (Surrey, 1987); and therefore, may seek empowerment from different sources than males, making the road to empowerment even more elusive. The issue of control is further confused since female nurses have traditionally been under the control of male physicians. What factors are associated with nurses' perceptions of their own personal and professional empowerment? Where can they look for improvement of their status? What can make them feel powerful enough to affect change both for their patients and for themselves?

Although nurses may be unable or unwilling to change certain variables included in this study, such as age, gender, and locale, results from this study may point out directional options to the individual nurse seeking empowerment. Perhaps a relocation, additional education, or a more autonomous practice role would help the individual nurse in his/her redefinition of empowerment.
Perhaps the nurse will be able to compensate for lack of organizational power by working on personal empowerment strategies, such as fitness or education.

Findings of this study may identify certain factors which relate to the empowerment of a unique population (registered nurses), as well as identify practical strategies which nurses may use toward self-empowerment. This work may assist the nurse executive to develop new recruitment and retention strategies. When nurses increase their knowledge of empowerment, they will be able to assist others to empower themselves.

**Problem Statement and Research Questions**

This study addresses the following questions: Is there a difference in personal empowerment between rural and urban nurses? Is there a difference between rural and urban nurses in organizational empowerment? Is there a difference in rural and urban nurses across the variables of age, gender, education, exercise frequency, or autonomy? Is there a relationship between personal and organizational empowerment for nurses? Is there a relationship between personal empowerment and the variables of age, gender, level of education, frequency of exercise, and autonomy? And, is there a relationship between organizational empowerment and the variables of age, gender, level of education, frequency of exercise, and autonomy?
Little is known about nurse empowerment and its factors of influence. Chandler (1991) identified that nurses in two large metropolitan hospitals scored generally low on an organizational empowerment scale. This study will remeasure organizational empowerment for nurses in Montana. Findings may point out differences in empowerment opportunities between rural and urban hospitals. Results from this research may assist the profession to determine an association of empowerment with educational preparation, autonomous roles, or physical fitness. Results may also assist the profession in targeting specific subsets for empowerment assistance.

**Conceptual Framework**

A conceptual model was developed illustrating the multidimensional quality of empowerment (see Appendix A), and suggested methods for measurement and analysis. The model encouraged formation of associations between the empowerment of nurses and the selected independent variables. The model below (Ripley, 1992) illustrates the suggested associations of the studied variables with personal empowerment.
Figure 1. Conceptual Model of Nurse Empowerment

\[ \text{Nurse Empowerment} = \]

\[ \text{Rurality} + \text{Age} + \text{Gender} + \text{Education} + \text{Personal Power} + \text{Organizational Power} \]

(Ripley, 1992)

A positive correlation is suggested between scores on the empowerment scale and the variables of education, exercise frequency, and autonomy because these variables have been associated with higher scores on similar concepts such as self-image, self-esteem, and self-actualization. A negative correlation is suggested between age and rurality and scores on empowerment scales because they have been associated with lower scores on such concepts. Further reference to these associations will be explained in Chapter Two.

Definitions

This study will use Rappaport's (1987) theoretical definition of empowerment: "a process by which people gain mastery over their affairs." Empowerment has been operationally defined as: an increase in one's sense
of control over one's personal or social situation, accompanied by feelings of confidence, security, and optimism.

**Personal power** is defined as: the "sense of control over one's life" (Trankel, 1991, p.54). Personal power will be measured by use of the Montana Empowerment Scale (Clark, Trankel and Brod, 1989).

**Organizational power** is defined as: the "total system effectiveness" within the organization (Kanter, 1977, p.166). This aspect of power will be measured by Chandler's Instrument based upon Kanter's Tools for empowerment (Chandler, 1991).

**Rurality** is defined as: employment in an area other than metropolitan statistical areas (MSAs) (Office of Management and Budget, 1983). Rurality of practice will be measured by requesting the respondent to write the location of employment.

**Age** is defined as: length of life measured in years, and is measured in decades: specifically, 21-30, 31-40, 41-50, >50 years.

**Gender** is defined as: sexual identity (male and female).

**Education** is defined as: years of academic pursuit. For the purposes of this study, education is quantified by degree received for academic achievement: associate degree, diploma, baccalaureate, and "higher" (meaning Master's degree or PhD).
Exercise frequency is defined as: vigorous physical exercise for a period of thirty (30) minutes, and is measured by number of times performed per week.

Autonomy is defined as: the amount of freedom and independence an individual has in task accomplishment (Hackman, 1976). For the purposes of this study, the indicators of autonomy will be subjective, with an opportunity for respondents to place their current level of autonomy on a 0-10 scale (0=no autonomy, 10=most autonomy). Other objective autonomy indicators will be identification with the three advanced practice roles of practitioner, anesthetist, and clinician; participation in a shared governance system; or billing separately for one's services. Two questions were designed by the researcher to assess autonomy in order to provide for the possibility that autonomy may be predominately subjective in nature, and have no association with role.

Assumptions

The following assumptions have been identified relating to this study and research:

1. Empowerment is a multidimensional concept.
2. Empowerment is subjective in nature.
3. Empowerment lacks a rigid conceptual framework applicable to most or all situations, and may therefore be difficult to measure.
4. The pervasive feel of powerlessness in nursing is a concern of the profession.
CHAPTER 2

LITERATURE REVIEW

The purpose of this chapter is to explore the concept of empowerment and its relationship to rurality, age, gender, education, exercise, and autonomy.

A comprehensive search of the nursing literature showed one quantitative study involving the concept of empowerment. Chandler (1992) used Kanter's Conditions of Work Effectiveness Questionnaire to study 268 nurses in two western hospitals. Chandler found that support, information, and opportunity were the factors which would result in increased motivation, risk-taking, and career aspirations. Although significant differences existed between the "somewhat powerless" and the "more powerless", the striking outcome of this study was the low mean empowerment level across the sample. Chandler's sample revealed nurses to be "stuck" from lack of organizational investment in them (Chandler, 1992).

The structural perspective on empowerment is well represented in the nursing literature. Gorman and Clark (1986), wrote about the Nursing Knowledge Project, which identified barriers to nursing practice, investigated how clinical nurses implemented their knowledge and skill, and evaluated training activities. Gorman and Clark evolved four strategies for empowering
nurses: (a) the practice of analytic nursing, (b) engagement in change activity, (c) improving collegiality, and (d) support from administration.

The practice of analytic nursing means using analytical skills for all problems encountered in the workplace; not just patient assessment and care planning, but for modification of the work environment and other projects. Analytic nursing would seem to increase nursing's collective locus of control and therefore improve the collective self-esteem. The notion of analytic nursing is similar to autonomy in increasing the amount of freedom and independence. This notion is supported by Adams-Ender (1990), who calls empowerment "directed autonomy," and maintains that each nurse should be treated as a source of creativity (p. 16).

Engagement in change activity is also verified by the staff of Nursing Management (1989), who editorialize that empowerment is to change as change is to empowerment. They state that successful change consistently empowers people and involves the concepts of responsibility, authority, and accountability. Manthey (1991) subsequently wrote about change activity in relation to nurse empowerment as a philosophy of nursing management.

A study of nurse retention issues found that "team playing" and "interaction and communication" categories were most important to nurses at Vanderbilt University Medical Center (Ames, Adkins, Rutledge, Hughart,
Greeno, Foss, Gentry and Trent (1992), supporting the *collegiality* concept of the Nursing Knowledge Project in which Gorman and Clark (1986) found that nurses had fewer collegial relationships than other professionals such as scientists and physicians. Carlson-Catalano (1992) identified specific actions to implement the four strategies suggested above by Gorman and Clark. The actions could be categorized under the headings of Kanter’s tools of information, supply, and support, with support being the most emphasized (Carlson-Catalano, 1992). Collegiality relates to the social aspect of empowerment, and entails appreciation of colleagues, stimulation of trust, and assistance to others to reach their full potential (Dobos, 1990). Gibson (1991) agrees, describing an increase in permeability of boundaries which develops a "sense of connectedness" (p. 358).

Support from management is cited by Trofino (1989), who advocates shared governance and participative management. Nursing has been calling for an end to powerlessness since at least 1978, when Kelly wrote that "administrators must be willing - no - *eager* to share power, to empower the practitioners" (Kelly, 1978, p. 468).

The concept of empowerment as a process has been called "elusive" (Solomon, 1976), and its definition as a personal attribute (empowered) is not universally accepted. Even Rappaport, who has done extensive writing on
empowerment, compares empowerment to obscenity in that it can be recognized but not easily defined (Rappaport, 1985). Webster (1983) defines the verb "empower" as "to give power or authority to; to authorize; to give ability to; to enable." (p. 595). And, the root noun "power" is defined as "the ability to do, capacity to act; capability of performing or producing" (Webster, 1983, p. 1412). In the working environment, empowerment may be viewed as specifically as the process of a manager's sharing of power with subordinates (Conger & Kanungo, 1988), or as liberally as permitting employees to perform tasks after giving them the authority to do so (Adams-Ender, 1990). Boughn (1991) viewed empowerment as a personal action, as "taking control" of one's own destiny. Rappaport (1984) felt that empowerment was a process by which individuals gain mastery over their affairs. However, Weis & Schank (1991) viewed empowerment from a social perspective, as "the ability to influence the behavior of other people" (p. 52). In the majority of social literature the concept of empowerment is transactional. Most sources agree that the root of empowerment is power, and so an examination of power is in order to clarify the confusion which can arise in the mind of the nurse in search of empowerment. The following discussion reviews concepts and theories basic to understanding the sources of empowerment and its components.
Personal Power

Power is an extremely valuable commodity in our society. Political and economic power struggles continue to motivate many great world events. Power in the form of electrical energy is used by virtually every home in the United States and Canada, and the control of energy continues to escalate in importance. Human power can be categorized in several ways. One primary distinction is between personal and social, or organizational power.

Individual personal power can be demonstrated as the capacity to effect change in one’s situation and even measured as physical strength, ability, or control. An example of individual personal power is the will, which is exerted to overcome physical or mental resistance or inertia. Personal power depends upon: (a) one’s self-actualization or self-esteem, (b) locus of control, and motivation sources. These concepts are discussed below.

Self-Actualization and Self-Esteem

Self-actualization is a concept developed by Abraham Maslow as part of the Human Needs Theory (Maslow, 1970). This theory is popular among psychologists despite its lack of empirical validation. Briefly, Maslow cites five levels of human needs. In ascending order, they are: physiological (hunger, thirst, warmth), safety, love and belongingness, esteem, and self-actualization. The first three levels are considered deficiency needs because motivation is
stimulated by lack of the quality. Self-actualization however, is a growth need, producing positive health. Maslow suggests that lower level needs must be fulfilled before higher level needs can be addressed, and this has been demonstrated empirically by Dunette (1976) and Davis-Sharts (1986). Marriner-Tomey (1992) have argued that the ordering of needs is different for some people, while Wanous and Zwany (1977) consolidated the hierarchy into two or three levels of need. Although Maslow believed that there would be a negative correlation between any two needs, this notion has been empirically contradicted by research (Rauschenberger, Schmitt, and Hunter, 1980).

Self-esteem is an older concept. Self-esteem refers to an individual's self-image when compared with his/her ideal self (James, 1890; Silber and Tippett, 1965). Self-esteem is believed to be a dynamic and changing picture (Silber and Tippett, 1965). However, Coopersmith (1967) maintains that persons with high self-esteem maintain stable images of their capabilities. Self-esteem is a personal judgement of worthiness (Coopersmith, 1967). Self-esteem is significantly dependent upon one's body-image (Cash & Pruzinsky, 1990). Body image is significantly related to fitness (Bonheur & Young, 1991), education (Kenney, 1991 and 1992), gender and locus of control (Adame, Johnson & Cole, 1989).
Maslow divided the esteem needs level into two parts: external and internal. External esteem needs are fulfilled from environmental sources such as status, recognition, attention, prestige, and appreciation. Internal esteem needs are fulfilled through achievement, competence, independence, freedom, and strength (Maslow, 1970). The needs shift and change depending upon one's circumstances; none has to be totally satisfied before another emerges. McClelland (1976) theorized that all motives are learned, and that strength of motivation to produce behavior varies from person to person depending upon past reinforcement. McClelland (1976) describes the power motive as a strong driving force to gain recognition for accomplishment. Therefore, feelings of empowerment may reinforce the motive, whether intrinsic or extrinsic. This work also places the need for empowerment at the external esteem level in Maslow's hierarchy.

Maslow examined and described self-actualization in depth. He defined self-actualization as a process of realizing one's potential and reaching a level of fulfillment, but never as happening at one given moment or as an end state. Despite the inability of researchers to confirm Maslow's Theory empirically, it continues to be taught in most schools of psychology, social sciences, management, and nursing. Yura (1986) based a handbook for nurse
supervisors on Maslow's Theory, claiming that "human needs supply the theoretical substance of the nursing process" (p.48).

Applying Maslow's Human Needs Theory to the present research study, this writer believes that the desire for empowerment falls within the levels of need for esteem and self-actualization. If one considers power as the ability to do or act (Webster, 1983), then logically power is potential energy available for use, and anything one does or receives which increases that commodity will be "empowering." Reconsidering Maslow's external and internal esteem sources, one can see that the sources of internal and external esteem will be empowering because they involve the transfer or growth of energy. External sources confer energy (power) in the form of status, recognition, etc. Internal sources affirm the awareness of energy (power) by flexing and developing it. The satisfaction of the esteem needs enables (empowers) one to make that leap between deficiency need and growth need, or to self-actualization.

Maslow (1971) describes self-actualized persons as:

"without one single exception, involved in a cause outside their own skin, in something outside of themselves. They are devoted, working at something, something which is very precious to them - some calling or vocation..." (p.43).

In other words, these persons are empowered. They are giving their energy to
something larger than themselves. In a sense, the ability to forget the four lower level needs in favor of the fifth may be an identifier of empowerment. So if one's self-esteem, belonging, safety, and physiological needs are being met, then one is relatively "empowered." This does not mean that self-actualized persons do not also need empowerment, but that self-actualization alone is insufficient for empowerment, or that empowerment is an ongoing process. Trankel (1991) found a similar phenomenon when she tested both empowerment and self-esteem among juvenile sexual offenders in Montana. Her results show that empowerment as measured by the Montana Empowerment Scale (MES) and self-esteem as measured by Rosenberg's Self-Esteem Scale are not the same attribute. She postulates that high self-esteem may be a component of empowerment, but that empowerment includes more than self-esteem. When one already possesses the "ability to do or act" (Random House, p.1039) then one needs only the tools to accomplish the work.

Self-esteem and self-actualization have been mentioned in the literature as being components of individual empowerment, and for this study will be measured within the Montana Empowerment Scale.

**Locus of Control and Motivation**

Empowerment is assumed to be a transactional concept, implying movement of power from one place to another. It can be said to change
location, or locus. Power can be seized, usurped, delegated, conferred, or assumed. The point at which most of the motivational power in a system exists can be referred to as the locus of control (Lefcourt, 1966).

Locus of Control of Reinforcement Theory sprang from Rotter's (1954) Social Learning Theory. Social Learning Theory is called an 'expectancy' theory because it refers to the place (locus) a person looks for behavior reinforcement, or a person's view of events as being consequent to one's actions and therefore under personal control. Characteristic patterns of behavior and thought identify persons as having predominantly internal or external locus of control (Lefcourt, 1982). "Internals" tend to be resistant to coercion, more inquisitive, and goal and achievement-oriented (Lefcourt, 1966, 1982). "Externals" tend to be more anxious, suffering, conformistic, and willing to resign themselves to what they perceive as "fate" (Lefcourt, 1966, 1982).

Bialer (1961), and Crandall, Katkovsky and Preston (1962) found that intelligence is positively related to perceived internal control. Bein, Anderson, and Maes (1990) verified previous studies linking high internal locus of control with job satisfaction in secondary school teachers. Locus of control also influences job involvement behavior (Noe & Steffy, 1987). The more external a person's locus of control, the more power is given to the environment. For example, the more a nurse desires to be assigned to any particular unit, the
more control (power) is given to the institution. Chandler (1992) discovered in a qualitative study that nurses looked predominantly to interactions with patients, their families, and physicians as their sources of empowerment.

Schnake's (1991) research on the "sucker effect" shows that negative social cues decrease work performance. Lefcourt (1982) suggests that characteristics identified with "internal" locus of control decrease the more one views oneself as being "at the mercy" of "capricious external forces" (Lefcourt, 1982, p.98). This means that the less a person perceives an ability to influence the environment, the less motivation exists to achieve or change it. O'Neill, Duffy, Enman and Blackmer (1988) supported this by studying citizen participation in social action, and found that citizen action is related to the belief that the citizen can correct social injustice; or, has control over his environment.

Deci (1975) agrees, and argues that the more internal a person's locus of control, the more his motivation comes from within (intrinsic). Deci (1975) defines two categories of intrinsically motivated behavior: the need to conquer challenges, and the need to seek challenge when none is present. His research on motivational theory demonstrated that the more one's rewards come from extrinsic sources, the more one seeks extrinsic validation, and the less intrinsic motivation one exhibits (Miner, 1980). Lawler, Armstead and
Patton (1991) demonstrated that Type A behavior focuses attention on extrinsic rather than intrinsic motivation.

Persons who score higher on self-esteem measures tend to set higher goals for themselves, indicating higher degrees of intrinsic motivation (Tang, Liu & Vermillion, 1987). However, Shapira (1989) found that goal assignment by a second person can be detrimental to intrinsically motivated persons who seek their own task difficulty. Vallerand, Gauvin & Halliwell (1986) concurred, finding that competition can decrease intrinsic motivation.

Positive feedback leads to higher levels of intrinsic motivation (Vallerand & Reid, 1988). Task variety and meaningfulness can promote intrinsic motivation (Lambert, 1991). And, praise of ability has been shown to increase motivation in men, but not women (Koestner, Zuckerman & Koestner, 1987).

Much of the empowerment literature from educational and counseling sources advocates changing the client's perception of the environment so that he/she views himself as having more control over and responsibility for his circumstances (Hsia, 1991; McWhirter, 1991; Nicholson & Matross, 1989). The sources also suggest that counseling efforts aim toward depersonalizing the experience of oppression and victimization (powerlessness) (Bowen, Bahrick & Enns, 1991). Social work literature contains a more divided and perhaps balanced approach toward changing both the client and the system (Rappaport,
1985; Pinderhughes, 1983). Wassermann (1991) suggests that the concept of empowerment has been present for fifty years in the theories of Rath, who states that unmet emotional needs disempower children. Some management sources maintain that empowerment is exclusively cognitive, and define it as increased intrinsic motivation (Thomas & Velthouse, 1990). Bolen (1992) maintains that motivation toward empowerment resides in the unconscious.

Locus of Control and motivation theories were used among others in the development of the Montana Empowerment Scale (Clark, Trankel & Brod, 1989). At least four questions on the MES were used with permission from an instrument specifically designed to measure locus of control. This study included the concepts of locus of control and motivation in the measurement of empowerment by using the MES.

**Social Power**

Social power is a broad, general concept which contains both personal and organizational power aspects. Social power is power in relationships. Social power is based on the notion that power is exerted by one person upon another. Social power is defined as: "the capacity to produce intended and foreseen effects on others" (Wrong, 1979). This capacity is expressed not only interpersonally, but intrapersonally as cultural norms and mores, which
accomplish what otherwise "would require informal social influence or the exercise of personal power" (Henderson, 1981).

Social power can be divided into personal (charismatic) and positional (legitimate) forms within an organization (Hersey and Blanchard, 1971), and is seen in social relationship as power versus dependence (Emerson, 1962). Several forms of social power have been identified by Wrong (1979), including force, manipulation, persuasion, and authority. French and Raven (1959) propose five bases: reward power, coercive (punishment) power, expert power, reference power (charisma), and legitimate power (authority).

Nurses seeking empowerment must decide whether they are looking for the power to accomplish an end, or power over others (authority). Although many nurses are in positions of authority, most of the nursing literature reflects the search for power in order to accomplish a goal, such as to promote health. This power to accomplish a goal is dependent upon one's position in the organization, and one's access to the necessary tools for work. Chandler (1991) discovered that nurses know that they do not possess much positional power. Although nurses are not at the bottom of the organizational hierarchy in most hospitals, they are low in the ranks of accountability as identified by licensure. Therefore, they may be using other aspects of social power, such as cultural norms or personal charisma to accomplish their organizational goals.
This study will test both personal power and organizational power to obtain a sense of the mechanisms nurses use to achieve their goals.

**Organizational Power Tools**

Rosabeth Moss Kanter's extensive work in the field of organizational behavior cites several power "tools" for the employee in an organization: information, resources, support, job activity, and opportunity (1977). Chandler (1992) specifically tested a nursing population with these tools and found information, support, and opportunity to be the three most significant tools. Within the organization, positions of power provide access to these sources, and persons who perceive the lack of these things perceive themselves and are perceived by others to be powerless (Martin, 1990). Kanter (1977) found women more likely than men to be "stuck" in these positions. Even for the self-actualized person, support, information, and resources are essential for accomplishing any task.

Hennig and Jardin (1977) come to a different conclusion. They propose that women employ different strategies than men in the workplace in order to influence their environment. They maintain that this difference is a result of learned experience, and will occur regardless of structural inequities. Mainiero's (1986) research on this debate found that persons in highly dependent jobs are more likely to acquiesce than those in more independent
(powerful) jobs, and that women in highly dependent jobs are more likely to acquiesce than men in the same jobs (Mainiero, 1986). Thompson (1981) found that women are more likely than men to share resources within the organization.

This study will view the construct of organizational power by assessing access to Kanter's tools of information, support, and opportunity. Access will be measured using Chandler's Instrument, based on the results of her 1991 research (Chandler, 1992).

**Rurality**

Rural populations consist of persons who are strong individualists; independent and opinionated (Stuart-Burchardt, 1982). They are more willing to accept responsibility for the effects of their actions, indicating a higher internal locus of control (Morrow, 1989). In the late 1980s, rural youth were found to aspire to less prestigious occupations and seek less education (Zimbelman, 1987). Crider, Willits, and Kanagy (1991) found that rural persons have slightly higher degrees of community satisfaction, and that they considered number of friends more important than income. Rural persons are likely to have stronger social support (Weinert & Long, 1987). Tilden and Gaylen (1987) have suggested that this may not always be positive in nature or
effect. Rural nurses may score higher on an organizational power scale because of social support rather than access to information or supplies.

Rural nursing theory rests upon the shared problems that rural persons face in accessing health care. Rural nurses share these problems in providing health care in unique situations. Rural nurses have been described as older, part-time workers, resistant to change, complacent, and lacking in leadership skills (Gluck & Charter, 1980; Ross, 1979). They have lower salaries and score lower on self-actualization inventories (St. Clair, Pickard & Harlow, 1986). Rural nurse generalists, who have great responsibility and must maintain expertise in all areas of patient care (St. Clair et al., 1986) may face great challenge in seeking empowerment. Rural nurses must travel longer distances to obtain higher and continuing education, and most work for smaller institutions with tighter budgets than large metropolitan medical centers. Although the rural setting mandates that nurses remain generalists (Scharff, 1987), expectations exist that the rural nurse provide the same standard of care as the urban nurse. They earn less money (St. Clair, et al., 1986), so their rewards for excellence are less tangible. Task variety, autonomy, low levels of routine, and high advancement prospects may be lacking in the rural hospital, and therefore limit the empowerment of the rural nurse (Block, 1987; Kanter, 1979).
Age

Few studies have been done comparing age with locus of control. Locus of control apparently does not change substantially throughout the income-producing years. However, age and locus of control do relate positively to career commitment (Colarelli & Bishop, 1990). Bein, Anderson, and Maes (1990) studied locus of control and job satisfaction among teachers in New Mexico, and found no significant relationship between age and locus of control. However, old age seems to be linked with a decrease in intrinsic motivation (Cox, Miller & Mull, 1986). Elderly women have been shown to score lower on Personal Power measures (Degelman, Owens, Reynolds & Riggs, 1991). St. Clair et al. (1986) found that older nurses scored significantly lower on self-actualization scores. This study may find that age is related to empowerment, thus strengthening the model which cites these components.

Gender

Nursing has been a traditionally female profession, with male membership remaining at less than 5% (U.S. Bureau of the Census, 1991). In Western society, tradition has given males the roles of power, control, and dominance (Friedle, 1975), and females have taken the dependent, supportive roles. This is an example of a power relation (Emerson, 1962); and conformity
to this relation has promoted the survival of our species. However, after generations of dependent or powerless roles, the end result for females is powerlessness (Solomon, 1976), and this state has resulted in a condition consistent with lower self-esteem (Coopersmith, 1967). As a result, the feminine attributes of receptivity, awareness of cyclic, creative forces in nature, and intuitive knowing have been devalued (Parker & McFarlane, 1991), and our society has become one which refuses to reward caring (Reverby, 1987).

Conditioning to accept a dependent social role could influence the development of locus of control. In order to have a strong internal locus of control, people must believe that they can determine their own fates; that they are free agents (Lefcourt, 1982). Therefore, females may be expected to have higher external locus of control than males. O'Neill et al. (1988) studied single mothers' perceptions of personal power and social injustice, splitting them into two groups; those who received welfare services and those who did not. They found that although personal power scores were higher for those mothers receiving services, social injustice scores were high for both groups. This would indicate that the group receiving services which supplied their lower-level needs on Maslow's hierarchy felt more effective in making changes. Lefcourt (1982) also states that achievement activity and long-range task behavior is diminished in those who view themselves as dependent upon the
whims of others. For the female, the sociocultural tendency is toward perceiving oneself in a relatively powerless, dependent position.

When males and females in similarly powerless positions were compared by Mainiero (1986), women tended to use acquiescence as a coping strategy more often than men. Mainiero's finding supports the socialization theory of sex differences in the organization; that is, differences between the power of men and women in the organization exist because of learned strategies for behavior rather than the structure of the job itself or the sexual identity of the worker.

**Education**

One of the most disempowering factors in nursing is the internal dissension over level of entry into practice. Adherence to a professional norm is essential to gain public respect (Styles et al., 1991); and educational preparation for licensure is the source of heated debate within the profession. "Knowledge is power," wrote Francis Bacon, indicating that knowledge and power have been linked for centuries in our cultural heritage (Bartlett, 1980). Weis and Schank (1991) state that values serve as a power base to unite the profession, and maintenance of empowerment depends upon embracing the
value of education and involvement. Professional unity must be achieved if nurses are to have collective power.

Education and locus of control are intertwined. Unless one has a substantial internal locus of control, one will not be motivated to achieve an education. "Internals" are more inquisitive, curious, and process information more quickly (Lefcourt, 1982). Research in motivation suggests that persons who strive for social approval desire to maintain a favorable self-evaluation (Coopersmith, 1967). By providing achievable goals and rewards, and an atmosphere of unconditional acceptance, education can assist in building self-esteem through providing a means by which one can approximate one's self-image with one's ideal (Silber & Tippett, 1965; Burns, 1979). Due to limited access to higher education opportunities in rural states, empowerment for nursing may also be limited. St. Clair et al. (1986) found that rural nurses have less education than their urban counterparts. Providing students with knowledge and skill is an essential component of empowerment by education (Funnell et al., 1991). Providing the client with enough information to maintain a level of self-determination regarding medical treatment is an empowerment strategy of social workers (Nicholson and Matross, 1989).

Kanter (1977) speaks at length about information as a necessary component of empowerment in the organization. This information can be
brought into a job by prior educational preparation, as well as accessed within. Continuing education in the form of programs and orientations is seen as a building block of self-actualization by several authors (Benson, Sweeny & McNicholls, 1982; Goin, 1977; Lewandowski & Kramer, 1980).

**Exercise**

Self-esteem has been defined as "feelings ...which reflect the relationship between the self-image and the ideal self-image" (Silber & Tippett, 1965). Therefore, reason suggests that the closer the self-image is to the ideal, the higher the self-esteem. Adame et al. (1989) and Davis (1990) found that physically fit persons had more positive attitudes toward their self-images. Feelings of power and effectiveness are cited as results of strenuous exercise or drugs (Shipley, 1988), or the opponent process (Solomon, 1980). Opponent process is a theory that positive feelings result from the resolution of opposite emotional states (Shipley, 1988). Following the resolution of a chronically stressful situation for instance, persons have reported new motivation, feelings of increased power and control, and are likely to credit others in the environment for the change. With exercise as with opiates, the presence of endorphins is accompanied by feelings of exhilaration and well-being (Hudack, Gallo & Lohr, 1986, p. 433). In exercise, the self may play both roles in the
power-dependent relationship, and the exercise process symbolically "works out" emotional tension. Feelings resulting from exercise may also be the result of overcoming one's personal inertia. These feelings may be identified as "empowering", especially when accompanied by a decrease in tension and the recognition of strength and growth produced by exercise (Phipps, Long & Woods, 1983, p. 229).

Fitness and exercise are closely aligned with self-esteem through ties with the body image (Cash & Pruzinsky, 1990). Exercise is also related to intrinsic motivation if the exerciser can see some effect (McAuley, Wraith & Duncan, 1991). However, Gauvin (1989) found no relationship between subjective well-being and exercise. This study will help to determine if a relationship exists between high empowerment scores and frequency of exercise.

**Autonomy**

Autonomy refers to the amount of freedom and independence an employee has in task accomplishment (Hackman, 1976). Dwyer, Schwartz and Fox (1992) found that nurses with a greater preference for autonomy gained job satisfaction as they gained decision-making influence in patient care and unit management issues. Gorman and Clark's (1986) four strategies for empowering nurses in the patient care setting are the following: analytic
nursing practice, engagement in change activity, strong collegial relationships, and administrative sponsorship. All support increased decision-making by nurses.

This discussion relates not only to the roles of nursing which are traditionally viewed as more autonomous (nurse practitioner, nurse anesthetist, and nurse clinician) but also to innovative organizational strategies cited in the literature as contributing to the empowerment of nurses. These organizational strategies fall under the descriptors of "shared governance" and "participative management." These strategies are aimed toward increasing staff nurse participation in decision-making (Manthey, 1991). They include staff nurse involvement in hiring procedures for new head nurses, scheduling, professional practice committees, and quality assurance (Trofino, 1989). Ames et al. (1992) addressed work retention issues at Vanderbilt University. The authors found that interaction, communication, and teamwork items were most important and satisfying to their sample. These items included indicators of support from coworkers and supervisors. The notion of mutual self-help is recurrent in empowerment literature (Rappaport, 1985). Taken together, these findings are consistent with the concept of internal locus of control. The nurses highly valued their ability to accomplish tasks together and make necessary changes as a group. In another study of autonomy, Allegrante and Michela (1990) found
that the implementation of a health enhancement program (HEP) for teachers in an inner-city school made the teachers feel that they had more involvement in decisions affecting them, even though the HEP did not directly address that aspect. Allegrante and Michela felt that the HEP was perceived as an indication of the school’s concern for the teachers’ health, producing a positive attitude and a sense of involvement. They identified this sense of increased involvement in decision-making as empowerment.

The three advanced nursing practice roles mentioned above (practitioner, anesthetist, and clinician) must be discussed at this point. These roles confer competent authority (Weber, 1968), which is based on specialized knowledge or skill. Empowerment is easily seen in the role of nurse practitioner. The nurse practitioner may legally diagnose and treat disease in collaboration with a physician. In practice, many patients who see a nurse practitioner never see the physician. To them, the practitioner is “the doctor.” This is an expanded nursing role, relatively autonomous, and has potential for creativity and holism. Results of interventions are seen quickly, enhancing belief in self-efficacy, and therefore empowerment (Conger & Kanungo, 1988). The nurse anesthetist is often the only person licensed and capable of providing anesthesia to rural populations in need of surgical intervention. Although the nurse anesthetist collaborates with the surgeon, the practice,
decision-making, and billing are independent, making this profession quite autonomous. The nurse clinician practices most often in a medical center, and is responsible for an expanded nursing practice and integration of relationships between departments. Nurse clinicians are less independent, but usually have a high degree of freedom. Freedom is important if one is to access the information necessary to complete one's tasks.

Rurality, age, gender, education, exercise, and autonomy of practice are variables which may influence the empowerment of nurses in the United States. The literature review conducted in this chapter has raised several other variables which may be associated with empowerment; namely, organizational level, full-time vs. part-time employment, advanced practice roles, and participation in shared governance.

Organizational Level

Organizational level may be related to empowerment due to increased autonomy and organizational power at higher levels in the hierarchy. A question is included in the research tool to indicate organizational level as staff, middle manager, upper manager, nurse executive, or other.
**Full-time versus Part-time Employment**

A higher proportion of nurses employed part-time may be associated with rural nursing (Gluck & Charter, 1980; Ross, 1979), and therefore should be considered as an associated factor if rural nurses score differently than urban nurses on either empowerment scale. A question is included in the tool for respondents to indicate full-time or part-time employment.

**Advanced Practice Roles**

Advanced practice roles have traditionally been viewed as more autonomous than other roles. A question will be provided for nurses involved in the advanced practice roles of nurse practitioner, nurse anesthetist, or nurse clinicians to identify their roles. Other advanced practice roles may be identified by a separate billing for services option in the same question.

**Participation in Shared Governance**

Participation in shared governance systems may correlate with increased autonomy as explained above. This research will provide an opportunity for nurses to identify involvement in successful shared governance systems.
This research will test the variables of rurality, age, gender, education, exercise, and autonomy against scores on the Montana Empowerment Scale and Chandler's Instrument to verify their influence. The research will also test the four additional variables identified above to determine their relationship with empowerment scores. Scores on the Montana Empowerment Scale and Chandler's Instrument will be correlated, as well as the independent variables with each other to discover possible associations.
The target population for this study was registered nurses currently practicing in the State of Montana. Montana is a predominantly rural state with two Metropolitan Statistical Areas (MSAs). Nurses sampled from this state provided a mix of both rural and urban practice in both hospital and community settings. The sampling unit was currently practicing registered nurses in both rural and urban areas. The sample consisted of a random list of two hundred (200) currently employed, practicing nurses obtained from the Montana State Board of Nursing. No specific formula was used to determine the sample size. Rather, the sample size was based upon an anticipated return of 80 useful questionnaires in order to compare results with St. Clair, Pickard and Harlow's (1986) study on self-actualization among rural nurses. While the sample seemed large for this type of study, the size was necessary to obtain an adequate return rate and to ensure adequate representation of certain independent variables estimated to be sparsely distributed in the state.
Design

This research was exploratory and descriptive. Personal empowerment was measured by the Montana Empowerment Scale (MES), and organizational empowerment was measured by Chandler's Instrument; and their association was tested with other variables of rurality of practice, age, gender, education, exercise frequency, and autonomy. Relationships were also tested between scores on the MES and scores on Chandler's measure of organizational empowerment (Chandler, 1992), which was derived from Kanter's ethnographic study (1977). Inductive reasoning was employed in analyzing results. The design was multivariate, with the independent variables of rurality of practice, age, gender, education, fitness, and autonomy compared with scores on personal and organizational empowerment measures. Finally, the variables suggested by the literature (level of responsibility within the organization, full-time/part-time work, role in nursing, and participation in shared governance) were compared with scores on the personal and organizational empowerment measures. The variables were measured once only with this sample. The design was correlational, using a sample of active registered nurses from all areas of the state and in many different practice settings. Participants were encouraged to complete the questionnaire in the comfort of their own homes to provide an atmosphere of quiet reflection.
Data Collection

To ascertain the reliability of the Montana Empowerment Scale on the nursing population, a pilot study was done using a sample of nurses working in a semi-rural county in Northwest Montana. The study was conducted at a small, 100-bed hospital. Although the pilot used a non-randomized, convenience sample distributed by hand, it was identical to the subsequent survey, and provided baseline information regarding the appropriateness of applying the MES to an employed population. Once reliability had been established, the survey was sent to a sample of 200 active, registered nurses in the state of Montana, using a randomized list obtained from the Montana State Board of Nursing. Addresses within the pilot hospital's county were deleted from the larger sample to avoid overlapping.

Current study data were collected from a mailed survey, which began on June 1, 1993. A single mailing was conducted, with a postcard mailed after two weeks. Return postage was included with the survey to increase return rates. Returns were accepted until August 1, 1993. The questionnaire was estimated to require twenty (20) minutes to complete. Data entry and computer analysis were completed by the researcher, and no identifiers were used which could link any respondent with any particular survey.
Instrumentation

The first part of the study questionnaire consisted of the Montana Empowerment Scale (MES), written and developed by Frank Clark of the Department of Social Work, and Mary Trankel and Rodney Brod of the Department of Sociology at the University of Montana (UM) in 1989. The purpose of the MES was to measure changes in positive personal power among participants in an intervention program (called "Options Unlimited"). The program was aimed at increasing the empowerment of adult recipients of Aid for Dependent Children (AFDC). The MES is a compilation of questions appended from other widely-used and reliable scales measuring powerlessness, alienation, anomie, and depression (approximately one-third of all questions). Positively worded questions are used as well, adapted from theoretical writings on empowerment. The questions are mixed to avoid "response set." A scaled response was used, including a "neutral" category, although inclusion of this created a decrease in variance.

Cronbach's alpha was used to test internal reliability of the scale after pretesting by the investigators, giving an overall split-half score of .91, indicating a high degree of internal consistency. On the 54 item questionnaire, the total variance was 462.09. Brod also did reliability analyses after decreasing the scale to 44 items (alpha .93), and again with 41 items (alpha .93). The scale
was reduced systematically, deleting the items which scored lowest on reliability measurements. After these three statistical "runs", the researchers believed that further reduction would not substantially increase the reliability, and therefore the full 54 items were restored to the scale. Correlation coefficients were then calculated to assess individual strength of association. Three items were found to be less strongly correlated. These three items were deleted from the instrument, leaving 51 questions, and raising the alpha to .93 (Clark, Trankel & Brod, 1989). The tool was then used in a pretest-posttest study to determine effectiveness of Options Unlimited, and again one year later on a different sample. An example of the original questionnaire with notation of the deleted questions is given as Appendix B.

Subsequently, Mary Trankel used the questionnaire in her doctoral research of youth sexual offenders at the Pine Hills correctional facility. This use of a tool in two widely divergent populations further helped to establish construct and content validity. Because Trankel used the tool alongside others which measured similar concepts such as self-esteem and found parallels in the results, she concluded that the MES was an adequate tool for measurement of personal empowerment. Although she did not find significant differences between groups tested, Trankel did find significantly higher scores among those who had undergone treatment (Trankel, 1991).
The second part of the study questionnaire was designed to assess organizational empowerment among nurses. This instrument was adapted by Chandler (1991) from Kanter's original ethnographic study of organizational power. For her sample of 246 nurses, Chandler found reliabilities for questions on information at .81, on support at .88, and on opportunity at .76. Chandler tested results in a comparative study between a for-profit hospital and a non-profit hospital in the eastern United States. She concluded that her sample identified support, information, and opportunity as critical to an empowering environment. On this scale, Chandler found that all the means were "quite low" (Chandler, p. 22), indicating a generally powerless state among the sample tested.

Chandler then refined her instrument for later application in her continuing study of empowerment. Since nurses had scored "quite low" on her scale, she did a qualitative, phenomenologic study on 56 staff nurses from five hospitals. She found that nurses look to collaborative relationships with physicians and patients' expressions of gratitude for the experience of empowerment. Interestingly, she found no evidence to support nurses looking to each other for empowerment. These findings would seem to indicate that either nurses perceive empowerment differently than other populations, or that nurses may be seeking empowerment from the self-esteem level; namely, validation through relationship with patients and physicians. Nevertheless,
Chandler revised her tool to include relational aspects. This revision consisted of seven parts. The first three sections addressed information, support, and opportunity (28 questions) and the last four sections addressed relationships (34 questions).

For this thesis work, only the first three sections of Chandler's tool were used because relationships were not a concept of the study design. Because Chandler had not tested this revised instrument, it was used on the principle of face validity. Differences between Chandler's first and second tools were slight in the areas of information, support, and opportunity. They consisted of splitting one question into two. A question on "the values and goals of management" was split to become two questions, one on values and one on goals of management. Also in the section on information, one question appeared twice, "This year's plan for your work unit." One of these questions was deleted in this project. Another question appeared twice in the new instrument, "Working together closely with your boss," occurring in both the opportunity section and the support section. One of these was deleted. The three sections used in this researcher's study were nearly identical to Chandler's first study. Further use of her original tool may be useful to Chandler for comparative purposes. A sample of this instrument is in Appendix C.
The instrument used in this study also consisted of questions relating to the six demographic questions of rurality, age, gender, education, exercise, and autonomy. These were assessed using nominal and ordinal data design. The additional four variables identified by the literature review (organizational level, full-time/part-time employment, nursing role, and participation in shared governance) were also assessed using nominal and ordinal data design.

Rurality was assessed by a completion question in which the respondent was asked to identify the town in which his/her workplace was located. Proximity was used rather than population because of the possibility that persons might not know the population of the town where they were employed. Proximity was also use to provide for nurses who might live in a rural area outside a metropolitan hospital and commute to work, or vice versa. The location of the employer defined rurality of practice, not the place of residence.

Age was broken into the segments of 21-30 years, 31-40 years, 41-50 years, etc. in order to compare with Chandler's divisions. Gender was assessed using a simple male-female alternative. Educational level was assessed using the division of Associate Degree, Diploma, Baccalaureate, and higher. The researcher estimated that this survey would not sample enough doctorally-prepared nurses to justify a separate category. Frequency of exercise was assessed using a ranked answer alternative question which assessed frequency of aerobic exercise for 30 minute periods; specifically
seldom, weekly, less than three times a week, and three times or more per week.

Autonomy of practice was assessed using a question in which respondents could select the job title of nurse practitioner, nurse anesthetist, nurse clinician (Master's prepared). A separate category was not provided for the certified nurse-midwife, but an option was given for persons who billed separately for their own services to provide for any autonomous role not anticipated by the researcher. A second question was added using a yes-no alternative to identify participators in effective shared-governance systems.

Organizational level was addressed for those working in institutional environments. Options included: staff, middle management, upper management, executive position, and other (specify). Full-time/part-time employment was identified using a nominal alternative. An example of the questions relating to the independent variables is included in Appendix D.

**Human Subjects and the Consent Process**

A cover letter accompanied each survey, explaining the purpose of the study, anticipated benefits, and assurance of confidentiality. All participants, being active registered nurses, were assumed to be legally competent. The questionnaire was written simply and plainly, with directions for completion at
the beginning of each section. Consent to participate was implied by return of the questionnaire. Human Subjects Review material was submitted to and approved by the Montana State University (MSU) College of Nursing during Spring Semester of 1993. Data collection began after approval of this committee was obtained.

The pilot study required cooperation of the Human Subjects Review Committee at a local hospital. Since no such committee existed, the Director of Nurses granted permission to distribute the questionnaires within the agency.

Completed questionnaires remain in the researcher's locked file until such time that the project is completed, whereupon they will be transferred to a locked file at Montana State University. Results of the survey will be made available to the authors of the MES, as well as Professor G. Chandler, in gratitude for their cooperation with this research. Completed statistical information will be summarized, and a report of the research submitted as thesis material to the Colleges of Nursing and Graduate Studies, Montana State University. A copy of the completed thesis will remain on file at the MSU Library. A shortened form of the research may be submitted for publication in a professional journal of the researcher's choice. The researcher may present the data accumulated in this study at a professional conference at her discretion.
Statistical Analysis

To obtain an overall picture of the data, frequency distributions of both the independent variables and the dependent variables were plotted as histograms. Means were calculated for both empowerment measurement scores, as well as comparative means for categories in the independent variables, such as education, age, and gender. Significant differences were calculated at the .05 level. Analysis of variance was used to identify the strength of relationships between the independent variables and the scores on the MES and Chandler's instrument. Significant differences were calculated at the .05 level. All computations were completed using a statistical computer application named Statgraphics Plus.

Limitations

This study was limited in scope to nurses currently practicing in the State of Montana, and therefore may not be generalizable to the greater population of nurses. Only two urban metropolitan statistical areas (MSAs) were available to compare with the rural nurses from the rest of the state, and urban nurses in Montana may not have responded to the questionnaire in the same way that urban nurses in more populated states would respond. Since the rural category
included such a wide range of practice settings, conclusions may not be representative of nurses in the most sparsely populated portions of the state.
CHAPTER 4

ANALYSIS

The purpose of this research was to assess Montana nurses' ratings on organizational and personal empowerment scales; and, to identify associations between those empowerment scores and the variables of rurality of practice, age, gender, education, frequency of aerobic exercise and autonomy of practice. Research strategy consisted of the selection and application of two empowerment scales - personal, as measured by the Montana Empowerment Scale (MES) and organizational, as measured by Chandler's instrument. These scales were augmented by questions measuring the independent variables of rurality of practice, age, gender, educational level, aerobic exercise frequency and autonomy of practice. Selected additional questions covered variables suggested by the literature review, namely organizational level, part-time versus full-time employment, role independence and participation in shared governance. Variance in scores on the MES and Chandler's instrument were analyzed with respect to rurality of practice. Levels of age, gender, education, frequency of aerobic exercise and autonomy of practice, as well as the additional variables of organizational level, full versus part-time employment, role in nursing and shared governance participation were each examined for relationship with each other. Then the MES and Chandler's
instrument were tested to determine whether a relationship existed between the two scales. Finally, variance among scores on the MES and Chandler's instruments were analyzed with levels of the other variables.

Prior to initiation of the research, a pilot study was conducted at a rural hospital, with thirteen registered nurses (RNs) responding to a convenience invitation to 20 RNs (staff size: 200 RNs). No one voiced concern with the length or semantics of the questionnaire. Subsequent analysis of the results from the pilot study and the larger study sample revealed no statistically significant differences between the two samples on either the Montana Empowerment Scale or Chandler's Instrument ($p < .05$).

Frequency distribution plots were used to determine whether the results of the dependent variables followed a normal distribution pattern. Since they were found to be normal in distribution, a parametric one-way analysis of variance (ANOVA) was conducted first to identify possible relationships between rurality of practice and scores on the Montana Empowerment Scale and Chandler's instrument. Then ANOVA was used to identify possible relationships between empowerment scores and the other nominal/ordinal variables of age, gender, level of education, frequency of aerobic exercise and autonomy. Organizational level, full-time versus part-time employment, role in nursing and shared governance participation were also examined. Because of
the findings described below, a correlation analysis was then used to determine whether correlations exist between the Montana Empowerment Scale and Chandler’s instrument.

Description of Sample

From the two hundred surveys mailed, 83 completed surveys were received. Partially-completed surveys were discarded unless isolated questions were unanswered. Several nurses wrote to say they were no longer employed in nursing and their surveys were discarded. Seventy-nine useful questionnaires were received, giving a useful return rate of 39.5%.

Independent variables were profiled using descriptive data analysis. Sixty-five percent of the sample practiced in a rural setting. The mode age was 31-40 years. The educational mode was baccalaureate level. Gender was 92% female. The mode of aerobic exercise frequency was 1-2 times per week. The mean score on the feelings of autonomy scale was 6.57 with a median of 7 and a mode of 8 (0=low, 10=high), indicating a relatively high degree of perceived autonomy. Sixty percent of the respondents were staff nurses and 75% of all the respondents were employed full-time. Eighty-eight percent reported that their role in nursing was not contained in any of the roles identified as more autonomous; namely, nurse practitioner, anesthetist, Master’s-
prepared clinician, or those billing for their own services. Only 25 of the 
respondents (36%) reported participation in an effective shared governance 
system and several questioned the definition of shared governance. 

Contrasts between rural and urban respondents were then profiled. The 
largest group of rural nurses were between 41-50 years, but the largest group of 
urban nurses between 31-40 years. Although the differences were not 
statistically significant (p=.23), this finding would support Gluck and Charter's 
1980 study in which rural nurses were found to be significantly older than urban 
nurses. Although the numbers of male respondents were low, this study found 
that the segment of males was 8.1%, contrasting with a national figure of 5%. 
Among the urban nurses, 11.5% were male. Thirty-one percent of the rural 
nurses were educated at the associate degree level and 35% at the 
baccalaureate level. In contrast, urban nurses were 15% associate-prepared 
and 65% baccalaureate-prepared. Rural and urban nurses differed significantly 
in their educational preparation (p=.05). Twenty-nine percent of the rural 
nurses exercised 3 or more times weekly, while 46% of the urban nurses 
exercised that frequently. In a frequency distribution curve representing 
subjective feelings of autonomy, rural nurses showed a wider, more gradual 
curve peaking at a score of eight with 20% of their sample, while urban nurses
showed a sharp peak at the score of eight, with 46% of their sample declaring that degree of autonomy.

Figure 2. Frequency of Subjective Autonomy Scores for Rural and Urban Nurses.

Contrasts between rural and urban nurses in relation to the additional variables showed that twenty-five percent of the rural nurses declared themselves to be employed in roles other than staff, middle/upper management, or executive, while only 8% of the urban nurses placed themselves in that category. Forty-nine percent of the rural nurses were employed at the staff level, compared with 81% of the urban nurses. More rural nurses were employed full-time (78%) than urban nurses (69%). More nurses employed in
autonomous roles such as nurse practitioner, nurse anesthetist, or clinical nurse specialist were employed in rural areas (16%) than urban areas (4%). No other nurses billed for their own services. Participation in shared governance was more prevalent among the rural sample (42%) than the urban (24%).

In comparison to their urban counterparts, rural nurses tend to be older, more likely to be educated at an associate-degree level, engage in aerobic exercise less frequently, and have a wider range of autonomy but at generally lower levels. If not employed in autonomous roles, they tended to be staff nurses working full-time. They also tended to participate in effective shared governance systems more frequently.

Results of Analysis

Following the demographic analysis, the research questions were addressed with statistical methods, according to the research questions.

Question One: Is there a difference between rural and urban nurses according to personal empowerment?

To answer the research question regarding differences between rural and urban nurses on personal empowerment, ANOVA was used to determine to measure the amount of variation in the data. No significant differences in
personal empowerment existed between rural and urban nurses when measured by the Montana Empowerment Scale \((p=.24)\).

Question Two: Is there a difference between rural and urban nurses according to organizational empowerment?

In an identical analysis using ANOVA, no significant differences in organizational empowerment existed between rural and urban groups when measured by Chandler's instrument \((p=.10)\).

Question Three: Is there a difference between rural and urban nurses across the variables of age, gender, education, aerobic exercise frequency or autonomy, or the variables of interest identified by the literature: organizational level, full-time/part-time employment, nursing role or participation in shared governance?

Except for the autonomy scale, the variables of concern were nominal or ordinal in nature and were placed in a contingency table with the rural/urban variable (Table 1). Additional variables of interest were also tested (Table 2).

There was no significant association between rurality and age \((p=.23)\), and there was no significant association between rurality and gender \((p=.43)\).

Significant differences were apparent in the educational background of nurses practicing in the rural/urban areas \((p=.05)\). A higher proportion of rural
nurses was educated at the associate-degree level. The greatest proportion of urban nurses was educated at the baccalaureate level. However, nurses who declared education higher than baccalaureate level were more prevalent in the rural setting.

A higher proportion of the urban nurses exercised more frequently (46.2%), but rural nurses were more evenly spread across the four levels of exercise frequency. No significant differences were present between the two groups (p= .28).

In regards to autonomy, the sample was surprisingly similar across the urban/rural distinction, with over half of each sample rating themselves as "7" or "8" on the scale (10=greatest autonomy). There were no significant differences between the groups in feelings of autonomy (p= .12).

A significant difference between rural and urban nurses did appear when crosstabulated with level of responsibility within the organization. Eighty-one percent of the urban respondents were staff nurses, compared with 49% of the rural nurses. Middle managers were equally represented across the two settings. No upper managers or nurse executives were represented in the urban sample, compared with 13.6% of the rural sample. Almost 25% of the rural nurses classified themselves as "other" than staff, middle management, upper management, or nurse executive (p<.05). The frequency of "others"
might indicate that more rural nurses function in unconventional levels within
the workplace, or that rural employers have flatter organizational structures,
leaving out the levels of middle and upper management.

There were no significant differences between rural and urban nurses
with respect to full/part time employment ($p=48$). Also, more of the independent
nursing roles were represented among the rural respondents, but the numbers
were so small that no associations could be accurately tested.

Although 42% of the rural respondents and 24% of the urban
respondents reported participating in shared governance, no significant
differences were found between the groups ($p=.15$).
Table 1. Comparison of Urban and Rural Nurses by Age, Gender, Educational Level and Aerobic Exercise Frequency.

<table>
<thead>
<tr>
<th>Sample N=79</th>
<th>Urban n=26</th>
<th>Rural n=48</th>
<th>X²</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21-30</td>
<td>9.5%</td>
<td>15.4%</td>
<td>6.3%</td>
<td>4.27</td>
</tr>
<tr>
<td>31-40</td>
<td>40.5%</td>
<td>50.0%</td>
<td>35.4%</td>
<td></td>
</tr>
<tr>
<td>41-50</td>
<td>33.8%</td>
<td>23.1%</td>
<td>39.6%</td>
<td></td>
</tr>
<tr>
<td>&gt;50</td>
<td>16.2%</td>
<td>11.5%</td>
<td>18.8%</td>
<td></td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>91.9%</td>
<td>88.5%</td>
<td>93.8%</td>
<td>.63</td>
</tr>
<tr>
<td>Male</td>
<td>8.1%</td>
<td>11.5%</td>
<td>6.2%</td>
<td>.12</td>
</tr>
<tr>
<td>(with Yates correction)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assoc. Deg</td>
<td>25.3%</td>
<td>15.4%</td>
<td>30.6%</td>
<td>7.78</td>
</tr>
<tr>
<td>Diploma</td>
<td>16.0%</td>
<td>15.4%</td>
<td>16.3%</td>
<td></td>
</tr>
<tr>
<td>Bachelor</td>
<td>45.3%</td>
<td>65.4%</td>
<td>34.7%</td>
<td></td>
</tr>
<tr>
<td>Higher</td>
<td>13.3%</td>
<td>3.9%</td>
<td>18.4%</td>
<td></td>
</tr>
<tr>
<td><strong>Exercise Frequency</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;weekly</td>
<td>28.0%</td>
<td>26.9%</td>
<td>28.6%</td>
<td>3.8</td>
</tr>
<tr>
<td>weekly</td>
<td>12.0%</td>
<td>3.9%</td>
<td>16.3%</td>
<td></td>
</tr>
<tr>
<td>&lt;3x/week</td>
<td>25.3%</td>
<td>23.1%</td>
<td>26.5%</td>
<td></td>
</tr>
<tr>
<td>≥3x/week</td>
<td>34.7%</td>
<td>46.2%</td>
<td>28.6%</td>
<td></td>
</tr>
</tbody>
</table>

(* p ≤ .05)
### Table 2. Comparison of Urban and Rural Nurses by Organizational Level, Full-time vs. Part-time Employment, Role in Nursing and Participation in Effective Shared Governance Systems.

<table>
<thead>
<tr>
<th>Sample</th>
<th>Urban</th>
<th>Rural</th>
<th>$\chi^2$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=79 n=26</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Level of Responsibility in Organization

<table>
<thead>
<tr>
<th>Level</th>
<th>Sample</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=79</td>
<td>n=26</td>
<td>n=48</td>
<td></td>
</tr>
<tr>
<td>Staff</td>
<td>60.0%</td>
<td>80.8%</td>
<td>49.0%</td>
<td>9.7</td>
</tr>
<tr>
<td>Middle Man.</td>
<td>10.7%</td>
<td>11.5%</td>
<td>10.2%</td>
<td></td>
</tr>
<tr>
<td>Upper Man.</td>
<td>6.7%</td>
<td>0.0%</td>
<td>10.2%</td>
<td></td>
</tr>
<tr>
<td>Executive</td>
<td>4.0%</td>
<td>0.0%</td>
<td>3.4%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>18.7%</td>
<td>7.7%</td>
<td>24.5%</td>
<td></td>
</tr>
</tbody>
</table>

#### Full-time versus Part-time Employment

<table>
<thead>
<tr>
<th>Employment</th>
<th>Sample</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=79</td>
<td>n=26</td>
<td>n=48</td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>74.7%</td>
<td>69.2%</td>
<td>77.6%</td>
<td>1.44</td>
</tr>
<tr>
<td>Part-time</td>
<td>24.0%</td>
<td>30.8%</td>
<td>20.4%</td>
<td></td>
</tr>
</tbody>
</table>

#### Role in Nursing

<table>
<thead>
<tr>
<th>Role</th>
<th>Sample</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Prac.</td>
<td>6.8%</td>
<td>4.0%</td>
<td>8.1%</td>
<td>2.8</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>4.1%</td>
<td>0.0%</td>
<td>6.1%</td>
<td></td>
</tr>
<tr>
<td>Clinician</td>
<td>1.4%</td>
<td>0.0%</td>
<td>2.0%</td>
<td></td>
</tr>
<tr>
<td>Sep. Billing</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>87.8%</td>
<td>96.0%</td>
<td>83.7%</td>
<td></td>
</tr>
</tbody>
</table>

#### Participation in Effective Shared Governance System

<table>
<thead>
<tr>
<th>Participation</th>
<th>Sample</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>35.7%</td>
<td>24.0%</td>
<td>42.2%</td>
<td>3.8</td>
</tr>
<tr>
<td>No</td>
<td>62.9%</td>
<td>72.0%</td>
<td>57.8%</td>
<td></td>
</tr>
</tbody>
</table>

(* $p \leq .05$)
Question Four: Is there a relationship between personal and organizational empowerment for nurses?

Correlation analysis between the Montana Empowerment Scale and Chandler's instrument for the entire sample showed a moderate, positive relationship between scores on the two instruments ($r=.59$, $p<0.0001$).

Question Five: Is there a relationship between personal empowerment and the levels of the variables of age, gender, level of education, frequency of exercise and autonomy for the entire sample?

ANOVA was used to test the differences between the levels of the nominal/ordinal variables and scores on the Montana Empowerment Scale. No significant differences were shown for the Montana Empowerment Scale and age ($p=.63$), gender ($p=.84$), level of education ($p=.17$), exercise frequency ($p=.77$), or feelings of autonomy ($p=.74$). Other variables of interest were also tested. No significant differences were shown for the Montana Empowerment Scale and level in the organization ($p=.39$), full vs. part-time employment ($p=.74$), nursing role ($p=.77$), or participation in shared governance ($p=.93$).

Question Six: Is there a relationship between organizational empowerment scores and the levels of the variables of age, gender, level of education, frequency of exercise and autonomy for the entire sample?
ANOVA was also used to test the differences between the levels of the nominal/ordinal variables and scores on Chandler's Instrument (Table 3). Significant differences existed among age groups ($p=0.02$), levels of education ($p=0.005$), and feelings of autonomy ($p=0.0007$). No significant differences existed for gender ($p=0.55$) or frequency of exercise ($p=0.96$). The other variables of interest showed significant differences for organizational level ($p=0.003$) and participation in shared governance ($p=0.0006$). No significant differences existed for different nursing roles ($p=0.86$), full vs. part-time employment ($p=0.42$).
Table 3. Organizational Empowerment and Characteristics of Nurses (ANOVA)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Variance Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Between Groups</td>
<td>0.953</td>
<td>3</td>
<td>0.318</td>
<td>3.508</td>
<td>0.019*</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>6.701</td>
<td>74</td>
<td>0.091</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>Between Groups</td>
<td>0.039</td>
<td>1</td>
<td>0.039</td>
<td>0.371</td>
<td>0.551</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>7.966</td>
<td>76</td>
<td>0.104</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>Between Groups</td>
<td>1.471</td>
<td>4</td>
<td>0.368</td>
<td>4.133</td>
<td>0.005*</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>6.587</td>
<td>74</td>
<td>0.089</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exercise</td>
<td>Between Groups</td>
<td>0.029</td>
<td>3</td>
<td>0.010</td>
<td>0.092</td>
<td>0.965</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>8.029</td>
<td>75</td>
<td>0.107</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autonomy</td>
<td>Between Groups</td>
<td>2.681</td>
<td>10</td>
<td>0.268</td>
<td>3.608</td>
<td>0.001*</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>4.905</td>
<td>66</td>
<td>0.074</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of Responsibility</td>
<td>Between Groups</td>
<td>1.573</td>
<td>4</td>
<td>0.393</td>
<td>4.485</td>
<td>0.003*</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>6.486</td>
<td>74</td>
<td>0.088</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full/Part-time</td>
<td>Between Groups</td>
<td>0.184</td>
<td>2</td>
<td>0.092</td>
<td>0.888</td>
<td>0.416</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>7.874</td>
<td>76</td>
<td>0.104</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Role</td>
<td>Between Groups</td>
<td>0.083</td>
<td>3</td>
<td>0.028</td>
<td>0.256</td>
<td>0.857</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>7.975</td>
<td>74</td>
<td>0.108</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shared Governance</td>
<td>Between Groups</td>
<td>1.363</td>
<td>2</td>
<td>0.682</td>
<td>8.230</td>
<td>0.001*</td>
</tr>
<tr>
<td></td>
<td>Within Groups</td>
<td>5.798</td>
<td>70</td>
<td>0.083</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(* p ≤ .05)

Due to the results obtained by these analyses, correlations were calculated to determine the strength of any relationship between organizational and personal empowerment and the variables of age, gender, level of
education, frequency of exercise, feelings of autonomy, level in the organization, full vs part-time employment, role in nursing and participation in shared governance. No statistically significant correlation was discovered between the Montana Empowerment Scale scores and any of the variables of age, gender, education, exercise frequency, autonomy, level in the organization, full versus part-time employment, or participation in shared governance systems.

However, Chandler's Instrument scores correlated strongly with feelings of autonomy ($r=.51, p=.00001$). Other positive correlations were with level of responsibility within the organization ($r=.37, p=.002$) and participation in shared governance ($r=.48, p=.00001$). None of the other variables of age, gender, education, exercise frequency or full versus part-time employment demonstrated significant correlations.

Finally, all of the nominal/ordinal variables were correlated against each other. Positive correlations were: age and organizational level ($r=.36, p=.003$), age and level of education ($r=.33, p=.006$), gender and role in nursing ($r=.43, p=.0002$), feelings of autonomy and participation in shared governance ($r=.44, p=.0002$), and feelings of autonomy and organizational level ($r=.49, p=.00001$). A mild inverse relationship existed between rurality of practice and level within
the organization; that is, rural nurses tended to have more responsibility within the organization ($r = -.29, p = .01$).

Interestingly, not one of the respondents answered the qualitative question which asked for a description of a situation where he or she had felt empowered. The placement of this question at the end of the survey may account for the lack of response.

In summary, the Montana Empowerment Scale (MES) tests personal empowerment. Prior to this application, the instrument had been used exclusively on dependent, disadvantaged populations. The lack of significant differences between groups in scoring on the MES may suggest that factors related to education, fitness, gender and employment make no significant difference to nurses' feelings of personal empowerment. More probably, the lack of significant differences suggests that the MES is not the optimal instrument for measuring personal empowerment in an employed, educated sample. However, scores on the MES were positively correlated with scores on Chandler's instrument.

Chandler's instrument tests organizational empowerment. The results show that increased age, higher education, increased responsibility within the organization, increased autonomy and participation in shared governance
systems are all positively associated with nurses' feelings of organizational empowerment.
CHAPTER 5

DISCUSSION

This study was undertaken to explore differences in empowerment scores among nurses. Empowerment was divided into personal and organizational aspects. Variables hypothesized to be related to empowerment levels were rurality, age, gender, education, exercise frequency and autonomy. Level in the organization, full-time versus part-time employment, role in nursing and participation in shared governance were added as variables due to their prevalence in the literature. The discussion in this chapter will refer sequentially to the research questions.

Research Questions

Question One: Is there a difference between rural and urban nurses according to personal empowerment?

Personal power was conceptualized to be an important component of overall nursing empowerment. From the literature review, personal power was thought to be comprised of a combination of self-esteem/self-actualization, motivation and locus of control. Self-actualization and self-esteem have been found to be lower among older and more rural nurses (St. Clair, Pickard &
A method was developed to measure levels of personal power by using a tool comprised of questions regarding self-esteem/self-actualization, motivation and locus of control (among others). This tool, called the Montana Empowerment Scale (MES), was used to assess differences in personal power between rural and urban practicing registered nurses in Montana.

The results showed no significant differences in personal empowerment between rural and urban nurses. Reasons for this are unclear. One possible reason may be that the instrument used to measure personal empowerment was unsuitable for the population surveyed; that is, employed, independent decision-making persons.

Another reason for lack of differences between rural and urban nurses on empowerment scales may be that the rural/urban definition for this study was based upon the United States' Office of Management and Budget (1983) distinction of a Metropolitan Statistical Area (MSA), that is a county with at least one city of at least 50,000 persons. Many of the respondents who practiced in areas other than Metropolitan Statistical Areas (MSAs) were employed in areas of higher population density, thus blurring the distinction between rural and urban. An example is the county of Missoula, population 65,000, which has two hospitals and all medical services short of transplantation. Around 45,000 persons reside within the city limits. Respondents practicing in Missoula may
think more like those from Billings or Great Falls (MSAs) than like those from a very rural or frontier community such as Twodot or Roundup. Alternatively, Elison's (1986) distinction of urban, rural and frontier areas could have been used to distinguish among rural and urban practice settings. Another approach could have requested the respondent to subjectively identify with a rural/urban alternative.

Another reason for lack of differences between rural and urban nurses regarding empowerment may be that personal power is conceptualized uniquely among the nursing population. Chandler's (1992) qualitative study of nurses revealed that 57% of nurses interviewed felt empowered by patient/family interaction and 23% by the nurse-physician interaction. These two sources of empowerment indicate reliance on external locus of control; not internal, as the MES measures. A tool more sensitive to the characteristics of nurses might be found to measure personal empowerment for this population. Finally, the most obvious possible reason is that there is no real difference between rural and urban nurses that relates to empowerment either personally or within the organization.
Question Two: Is there a difference between rural and urban nurses according to organizational empowerment?

Organizational empowerment was measured by Chandler’s Instrument, which is based upon the work of R. M. Kanter (1977). Kanter specifies three sources of empowerment in the work environment: opportunity, support and information. Again, no significant differences were found between nurses practicing in urban areas and those practicing in rural areas. Like the first research question on personal empowerment, this lack of difference may reflect the method used to distinguish between rural and urban practice. Another reason for the lack of difference between rural and urban nurses is that opportunity, support and information access may be a function of the individual organizational culture rather than of rurality (Kanter, 1977; Eisenberg & Goodall, 1993). If this is the case, each institution would reflect differing empowerment scores among its nurses, but grouped together with other institutions according to community size, would lose its individual variation.

Question Three: Is there a difference between rural and urban nurses across the variables of age, gender, education, exercise frequency, autonomy; or organizational level, full versus part-time employment, practice role and participation in shared governance?
Age. Like St. Clair, Pickard and Harlow's (1986) study of self-actualization among rural and urban nurses, this study found that rural respondents tended to be older. Although the means for this study did not differ as significantly as theirs, apparently nurse profiles in Montana may be similar to those in north central Texas. Reasons for this are unclear. One might speculate that new graduates seek initial employment in the larger metropolitan areas, near their alma maters or in hospitals which provided them clinical experience. They may find the larger areas more culturally or professionally stimulating or they may simply seek higher reimbursement. These questions are material for further study.

Gender. Although only six male nurses participated in the study, it may be concluded that the proportion of male nurses in this random sample exceeded the national average. Reasons for this result are unclear. Male nursing is a nontraditional role. The only significant gender correlation was with the more autonomous roles in nursing ($p=.0002$). One might speculate that males would naturally work toward the more independent nursing roles, perhaps due to a stronger internal locus of control.

Education. Educational levels were more evenly distributed among rural nurses than urban nurses. However, urban nurses were more likely to be
baccalaureate-prepared than rural nurses, affirming the findings of St. Clair, Pickard and Harlow (1986). Although all three baccalaureate programs in Montana are located in rural areas, the state university has extended campuses in urban areas which are affiliated with urban hospitals for clinical experience. Graduates of baccalaureate programs may remain in the cities for many reasons, such as salary, opportunity for experience, continuing education and advancement. With the exception of those educated beyond the baccalaureate level, apparently the more highly-educated nurses are not returning to the rural environment unless in advanced practice capacity (if they originated from the rural environment at all). Caution must be used against premature formation of conclusions without trending this data.

The fact that those educated beyond the baccalaureate level were more highly represented in the rural sample may be related to the greater representation of the more autonomous roles in the rural sample, although one must be careful not to assume that all rural nurse practitioners or anesthetists have Master's degrees.

Interestingly, the proportion of the total sample which possessed more than baccalaureate level education corresponds closely with St. Clair, Pickard and Harlow's 1986 study of self-actualization among rural nurses. However, an important difference is shown. In the Montana sample, the higher educated
nurses were in the rural environment, while in north central Texas the higher educated nurses remained in the urban setting. Since six years separate the two studies, trending the mobility of Master's-prepared nurses might be of use. Also of interest would be followup studies to investigate reasons for remaining in the urban arena. Another study might be conducted of those Montana nurses with education beyond the baccalaureate level to determine their motivations for obtaining higher education and returning to or remaining within the rural environment.

**Exercise.** Sixty percent of the entire sample indicated that they engaged in aerobic exercise for 30 minutes or longer, more often than once weekly. Urban nurses exercised more frequently than the rural sample (46.2% exercised 3 times a week or more, contrasting with 28.6% in the rural group). Reasons for this difference are unclear. If a significant proportion of the rural nurses had farm/ranch chores, they may view the necessity of aerobic exercise differently than urban nurses or they may not have the time as farming often takes precedence in rural areas. Additionally, a variable containing a breakdown of shift length might have been useful for correlations, as twelve-hour shifts may be less conducive to regular exercise if nurses are more fatigued after working longer hours.
Organizational Level. Staff level nursing was more highly represented (80.8%) in the urban sample, but the representation included all levels. Conversely, upper management and nurse executive levels were not represented in the rural sample. While this may represent a product of sampling, it might also indicate that more rural nurses function in unconventional levels within the workplace or that rural employers have flatter organizational structures, leaving out levels such as middle and upper management. Since Lee found that rural hospitals frequently have fewer than 100 beds (cited in Bushy, 1991) there may be less need for upper management or nurse executive levels in hospitals of that size.

Rural and urban nurses did not differ significantly in organizational empowerment in spite of upper level representation in the urban sample. This finding might support the notion that organizational empowerment is not position-dependent. Chandler's (1991) study concluded that "nurses recognize that they do not have positional power." Theoretically, a nurse in any position who lacked supply, information and support would feel a lack of empowerment. However, with only twenty-six percent of the entire sample reporting a level above that of staff nursing, the idea warrants a more focused study.

Full-time vs. Part-time Employment. About seventy-five percent of the sample worked full-time. Exactly 10.4% more urban nurses worked part-time than rural nurses, contradicting Gluck and Charter's 1980 finding, where more
part-time nurses practiced in the rural setting. Results from this study may indicate either demographic or economic trends in nursing toward more full-time employment or a trend specific to the urban/rural distinction. The reader must remember that thirteen years separate the two studies. More investigation is needed, as the perception of economic insecurity may have influenced scores on the personal empowerment scale.

**Autonomy and Autonomous Roles.** Only twelve percent of the respondents answered that they were employed in one of the traditionally autonomous roles for nurses: nurse practitioner, nurse anesthetist or master's-prepared nurse clinician. The proportion of nurse practitioners in the rural component (8.1%) was twice as great as that of the urban (4%). All the nurse anesthetists and nurse clinicians were in rural settings. No respondents reported separate billing for their services.

On the subjective autonomy scale, the mean for both rural and urban groups was at 8 on a scale of 1-10. Distribution curves were fairly similar (Figure 1, Chapter 4). This finding suggests that feelings of autonomy do not differ between rural and urban nurses. The finding also suggests that feelings of autonomy are moderately high across both samples.
Participation in Shared Governance. Only twenty-four percent of the urban nurses stated that they participated in an effective shared governance system, contrasted to 42% of the rural nurses. This may be explained by a flatter hierarchy in rural, small hospitals. A few respondents wrote in questions regarding the definition of shared governance, which had not been provided in the questionnaire. Several respondents left the answer blank. This led the researcher to doubt the reliability of conclusions based upon answers to this question. Perhaps rural nurses perceived their organizational "voice" to be heard strongly enough to qualify for the spirit of shared governance (Eisenberg and Goodall, 1993). Nothing was found in the literature search relating the rural/urban distinction and the practice of shared governance.

Question Four: Is there a relationship between personal and organizational empowerment for nurses?

Results show a weak positive relationship between scores on the Montana Empowerment Scale and Chandler's Instrument. While this finding may begin to support a mathematical construct as was suggested in the conceptual framework of this study, it would be premature to suggest that no other variables exist to influence the result of the equation. This finding may be a basis for further study to see how the two might influence each other. Research questions might be: Do nurses who are personally empowered seek
organizationally-empowered positions? Or, are feelings of personal empowerment augmented by organizational empowerment?

**Questions Five and Six:** Is there a relationship between personal (5) or organizational (6) empowerment and the variables of age, gender, level of education, frequency of exercise, feelings of autonomy, level in the organization, full vs part-time employment, role in nursing and participation in shared governance? (Due to the similarity of results for these two questions, they will be discussed together).

**Age.** Scores on personal and organizational empowerment were not related to age, reinforcing research done on age and locus of control by Bein, Anderson and Maes (1990) and age and personal power (Degelman, et al, 1991). Since St. Clair, Pickard and Harlow (1986) found that self-actualization had a significantly negative correlation with age, one might question the argument that personal empowerment is related to self-actualization in this sample. Although traditionally perceived as mentors or as having greater influence, older nurses were not shown to have perceptions of greater organizational empowerment than younger nurses.
Gender. Males did not score significantly different from females on either personal or organizational empowerment. For further research, a stratified random sampling method could be used to investigate differences in empowerment by gender in order to test Solomon's (1976) theory that repeated dependent roles produce powerlessness and Coopersmith's (1967) gender-related low self-esteem theory.

Education. Level of education was positively correlated to greater organizational empowerment. This finding suggests that nurses with higher education have a greater perception of their access to information, support and opportunity. Since this study was subjective, one must be careful not to assume that they actually have measurably greater access. But the finding reinforces Kanter's (1977) emphasis on information, support and opportunity as tools of organizational empowerment. This positive correlation also documents the need for access to higher education for the nurse.

However, Lefcourt's theory that those with higher internal locus of control achieve higher education was not verified in this study by correlations between education and personal empowerment scores (Lefcourt, 1982). Since gender socialization may influence internal versus external locus of control, this finding might have been different had a gender-stratified random sample been used.
Exercise. Frequency of exercise was unrelated to any of the other variables considered. Although this lack of relationship disputes the proposed relationships between self-esteem and intrinsic motivation with exercise, it supports Gauvin's (1989) finding of no significant relationship between subjective well-being and exercise. Despite Adame, Johnson and Cole's (1989) and Davis' (1990) findings that physically fit persons have better self images and effectiveness (Shipley, 1988), there was no relationship for this sample. If there is indeed a relationship for a greater number of persons, perhaps the components of self-esteem and intrinsic motivation lack enough weight within the MES to be able to detect it. Further study with instruments specifically designed to measure self-esteem and intrinsic motivation are warranted. The opponent-process theory related in Chapter 2 may have more influence than realized by this researcher and was not tested by the MES (Shipley, 1988).

Autonomy. Although no relationship was found between personal empowerment and feelings of autonomy for this sample, a moderately strong positive relationship existed between organizational empowerment and feelings of autonomy. The strength of this relationship suggests that the nurse with the opportunity, support and enough information to make a decision will also perceive her(him)self to be autonomous. The finding is consistent with the
study by Ames et al. (1992) on work retention issues at Vanderbilt University. Also verified are Allegrante and Michela's (1990) findings on teacher empowerment. In fact, they defined empowerment as increased involvement in decision-making. From the literature and from this study, one may safely conclude that autonomy and organizational empowerment are closely aligned and distinctions between the two must be more clearly defined for accurate measurement.

**Level in the Organization.** Sixty percent of the entire sample rated themselves as staff nurses. Although there was sparse representation among upper managers from the urban practice setting, there was enough general representation of middle and upper management to suggest a conclusion. Despite the lack of relationship between scores on the MES and level in the organization, level within the organization was positively correlated with organizational empowerment. This correlation suggests that managers perceive themselves to have greater access to information, support and opportunity. The correlation also supports the literal and traditional definition of empowerment: "to give power or authority to; to authorize..." (Webster, p.595). This finding is hardly surprising, as Kanter's (1979) work described empowered
behaviors as including high career aspirations, achievement orientation, motivation and risk-taking (all characteristics of management potential).

**Full vs. Part-time Employment.** No relationship was shown between full versus part-time work and organizational or personal empowerment. Apparently, multiple days away from the workplace does not influence nurses' perceptions of their access to information, support and opportunity. Perhaps the reasons which influence a person to work part-time reflect a difference in priority, such as family, other job or duties, or an external means of support. If these other priorities somehow fulfilled that need which others seek to meet within the organization, no difference in perception would exist. Further study is needed in this area.

**Autonomous Roles.** Roles in nursing were not significantly related to either personal or organizational empowerment. Since less than ten percent of the sample was involved in an autonomous nursing role, any conclusions based upon this finding would be premature.

**Participation in Shared Governance.** Thirty-six percent of the total sample declared that they were involved to some degree in a shared governance system. Since several respondents indicated doubt as to the
definition of shared governance on their surveys, conclusions based upon answers to this item on the questionnaire may be tenuous. However, the interesting result of this analysis is the moderately strong correlation between participation in shared governance and organizational empowerment. Since shared governance is advocated strongly in the literature as a tool to empower nurses by sharing of administrative power, one might conclude that this study verifies that claim.

**Other findings of interest.** Age was found to correlate positively with level of responsibility in the organization \((p=0.003)\). Similarly, age and scores on organizational empowerment were positively related. This indicates that in Montana, organizational empowerment may increase with advancing age and verifies the earlier finding that age and intrinsic motivation relate positively with job commitment (Colarelli & Bishop, 1990).

Level of education was positively correlated to level of responsibility within the organization across the entire sample \((p=0.0058)\). This finding suggests that higher education is being both utilized and rewarded by promotion in Montana. Studies could be done from data obtained by the Montana State Board of Nursing to both trend and confirm these results. If confirmed, these findings would encourage the development of higher
education programs in the state, greater allocations to fund advanced practice education, plus the addition of an administrative track in the graduate curriculum at the State University.

A positive correlation was found (0.44) between gender and the autonomous roles, as mentioned above (p=.0002). Again, the small sample size makes conclusions inadvisable.

Feelings of autonomy were high among those in management (p<.0001). This is an expected correlation given the relationships between level in the organization and autonomy. The surprising finding is that the autonomous roles in nursing are not positively correlated with perceived autonomy as measured on the autonomy scale. Apparently, autonomy is at least partially subjective in nature and is not assured by a more independent role or level in the organization. Could it be that autonomy is perceived not by its association with independence but by its association with interdependence? Further research is needed in this area.

Feelings of autonomy were also significant in those who participated in shared governance systems. One of the purposes of shared governance is to involve nurses at the staff level in decision-making (Manthey, 1991), so this result is not surprising and will serve to augment current research regarding
shared governance. Full-time versus part-time was unrelated to any other variable tested in the study.

Conclusions

The findings from this study cause the researcher to reexamine the conceptual framework theorized in Chapter One, as well as the tools used to test the framework. Due to the lack of support gained from this study for the personal empowerment component of the model, one must conclude that either the model is faulty or the tool measuring personal empowerment lacks congruence with the population sampled. Although well-supported in the literature, no significant relationships between personal power and any of the independent variables of gender, rurality, education, autonomy, fitness or age were found in this research. Prior to this application, the MES had been used exclusively on dependent, disadvantaged populations. The fact that there were no significant differences between groups in scoring on the MES may suggest that factors related to education, fitness, gender and employment make no significant difference to nurses' feelings of personal empowerment. More likely, it suggests that the MES is not the optimal instrument for measuring personal empowerment in an employed, educated sample.
On the other hand, associations with measurements of organizational power are verified by this research. Chandler's Instrument, which was designed for and tested upon nurses may have increased validity as a result of this work. Support, access to supplies and information, and opportunity may be more available in an organization rather than in private practice.

Implications exist within these results for those planning the future of nursing education. If nurses educated at the baccalaureate level can be expected to remain within the metropolitan area and nurses educated at higher levels return to the rural environment, then programs must be developed and resources allotted to further study the reasons for this phenomenon. Educational strategies may need adjustment to fit the needs of rural Montana.

Implications also exist for those seeking empowerment through the perceived-independent roles of nurse practitioner, nurse anesthetist or nurse clinician. Possibly, these roles do not afford the practitioner the degree of empowerment that organizational responsibility does.

Caution must be exercised in interpreting these findings. Results from a small sample of nurses in a predominantly rural state cannot be extrapolated to any other area of the country. Reasons for these findings may lie deeper in the psychology of nurses or in the rural culture of nursing than this questionnaire can possibly tap. Nurses may have traditionally sought or been conditioned by
roles which support extrinsic motivational behavior and encouraged an evolution toward external locus of control. Further research is imperative in this rapidly expanding area of professional psychology of empowerment.


Staff (1990). Congress clips hospitals, MDs, but funds rural NPs' services. The American Journal of Nursing, 90(12), 82.


Appendix A

Conceptual Model of Empowerment
EMPOWERMENT

= 

Personal Components

- Self-esteem
- Self-actualization
- Locus of Control
- Motivation

+ Organizational Components

- Reward
- Coercive
- Expert
- Reference

Tools:

Information
Support
Opportunity

(Ripley, 1992)
Appendix B

Montana Empowerment Scale

by Clark, Brod & Trankel, 1989
(Uses a scaled response of Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree)

1. I have valuable ideas to share with others.
2. Success is more dependent on luck than real ability.
3. There are so many decisions that have to be made, that some days I feel I could just "blow up."
4. I am comfortable with the fact that I am sometimes different from other people.
5. There's little use trying to improve because it's not really possible to get ahead in today's world.
6. I can say exactly what I think.
7. I feel I can achieve my full potential.
8. I find it hard to stay committed to the goals I set for myself.
9. I become embarrassed when others compliment me.
10. I am more aware of my personal power than most people.
11. I sometimes feel there is no point making plans, because something usually happens to ruin things.
12. My personal strength is a source for others.
13. A person has to live pretty much for today and let tomorrow take care of itself.
14. I can tell you what my work goals are.
15. I have my own rights as a person.
16. I'm not really sure what I want out of life just yet.
17. I feel independent as a person.
18. It is only wishful thinking to believe that one can really influence what happens in society at large.
19. I can say exactly what I feel.
20. I have a realistic chance of accomplishing my personal goals.
21. The costs of success are usually greater than the rewards.
22. I feel strong as a person.
23. People change for the worst after they become successful.
24. I can live according to my personal values.
25. I inspire others to work toward their goals.
26. I enjoy telling my friends that I have done something especially well.
27. My feelings are clear to me.
28. I frequently feel depressed these days.
29. I feel I am responsible for my own well-being.
30. I can recognize and resist attempts by others to control my life.
31. Sometimes I feel that I don't have much control over the direction my life is taking.
32. I can directly confront others who don't respect my rights or feelings.
33. I am easily beaten in an argument.
34. The important people in my life actively encourage me to achieve goals I set for myself.
35. deleted
36. deleted
37. One a person achieves his/her current goal, he/she should set a new, more challenging goal.
38. Part of my motivation in working to achieve my goals is to make the world a better, more positive place in which to live.
39. deleted
40. Feeling that I have personal strength is a way of life for me.
41. I expect and need others to appreciate me.
42. I think I have a positive influence on others.
43. I feel a sense of kinship with other women (or men).
44. I do not feel there is much exploitation or discrimination in our society any more.
45. I feel my contributions and opinions are as valid as those of the important persons in my life.
46. I am not afraid to differ with important persons in my life.
47. I feel able to challenge myself to improve previous performances.

48. In my attempt to better myself, I will probably lose many friends who are important to me.

49. I do not feel threatened by looking at mistakes I have made.

50. I feel I will ultimately influence the larger community.

51. I am able to express my fears about what happens in my life.

52. Many times I feel I have little influence over the things that happen to me.

53. I feel I can learn from all my life experiences, whether good or bad.

54. I can recognize the many strengths in others.
Appendix C

Chandler's Instrument

(as revised for this study by Ripley)
I. How much of the kind of opportunity do you have in your present job?
   a. Challenging work
   b. The chance to gain new skills and knowledge on the job
   c. Access to training programs for learning new things
   d. The chance to work together closely with your boss
   e. The chance to learn how the hospital works
   f. Tasks that use all of your own skills and knowledge
   g. The chance to advance to better jobs
   h. Rewards for jobs well done

II. Circle the number that best indicates your access to information:
   a. The current state of the hospital
   b. The relationship of the work of your unit to the hospital
   c. How other people in positions like yours do their work
   d. The values of top management
   e. The goals of top management
   f. This year's plan for your work unit
   g. How salary decisions are made for people in positions like yours
   h. What other departments think of your unit
   i. What patients think of the work in your unit

(Uses a scaled response of 1-5; 1=none, 3=some, 5=a lot.)
III. Please circle the appropriate number for different types of support that might be available to you.

a. Specific information about things you do well
b. Specific comments about things you could improve
c. Helpful hints or problem solving advice
d. Information or suggestions about job possibilities
e. Discussion of further training or education
f. Help when there is a work crisis
g. Help in gaining access to people who can get the job done
h. Help in getting materials and supplies needed to get the job done
i. Rewards and recognition for a job well done
Appendix D

Independent Variables
1. My age is:
   a. 21-30
   b. 31-40
   c. 41-50
   d. 51 or greater

2. The highest level of education I have attained is:
   a. Associate degree
   b. Diploma
   c. Baccalaureate
   d. Higher

3. My gender is:
   a. male
   b. female

4. Aerobic exercise is that which sustains a heart rate equal to or more than 85% of its capacity. The number of times I engage in aerobic exercise for 30 minutes or longer per week are:
   a. ≥3 times/week
   b. <3 times/week
   c. weekly
   d. less than weekly
5. I am currently employed as a:
   a. staff nurse
   b. middle manager
   c. upper manager
   d. nurse executive
   e. other

6. My position is:
   a. full time (≥36 hrs/wk)
   b. part time (<36 hrs/wk)

7. My role in nursing is as a:
   a. nurse practitioner
   b. nurse anesthetist
   c. nurse clinician (Master's prepared)
   d. other but I do separate billing for services

8. Please mark your feeling of autonomy in your practice on the line below.

   0 1 2 3 4 5 6 7 8 9 10

9. I participate in an effective shared governance system.
   a. yes
   b. no
10. The town where my **workplace** (not home) is:


11. Please take a moment to describe the situation in which you most recently felt yourself to be empowered.


Appendix E

Permission to Use

Montana Empowerment Scale
Dear Jill:

Thank you for your interesting note! The empowerment articles are interesting, and I've passed them around for others also.

Yes, you are completely at liberty to use our empowerment scale in your research, and to share it with others. That was thoughtful of you to ask.

Unfortunately, the SASE you provided has been mislaid. As a result, I can't respond on it. If you would like me to do that I will. Otherwise, please consider this full permission to utilize the scale.

Take care, and I will look forward to hearing how your research is going. Keep in touch.

Sincerely,

Frank Clark, Ph.D.
Professor and Chair
Appendix F

Permission to Use

Chandler's Instrument
STATEMENT OF PERMISSION TO USE

In preparation for partial fulfillment of the requirements for a master's degree at Montana State University College of Nursing, I agree that Jill B. Ripley has permission to use a tool I developed for assessing organizational power among nurses:

______________________________
(please insert proper name if appropriate)

______________________________  ______________________
Genevieve Chandler, Assistant Professor  Date
Division of Nursing
University of Massachusetts at Amherst
216 Arnold House
Amherst, MA 01003
Appendix G

Approval to Collect Data
May 20, 1993

TO: Jill Ripley

FR: Julie E. Johnson  
    Associate Dean

RE: Human Subjects Review

Thank you for revising your Human Subjects material as requested by the Committee. The revisions are satisfactory and you may proceed with your project "Nurse Empowerment".

Best wishes for success with your study.

JEJ/lt

cc: Missy Korb
Appendix H

Letter to Participants
Dear Montana Nurse,

The subject of empowerment pervades our professional literature. We are advised to empower our patients, our communities, and our profession. Yet, little research has been done to assist us in knowing precisely what empowerment is or how to go about finding it.

Your name was randomly selected with 199 other actively registered nurses in the state of Montana to participate in a research project on Nursing Empowerment.

The enclosed questionnaire includes two tested tools for assessing empowerment, both individual and organizational. It also includes some demographic questions. There are no foreseeable risks to you for participation in the study. Your completed questionnaire will be treated confidentially, and all data will be reported as group data. Raw data will be available only to the researcher, the data entry person, and the thesis advisor, and may be retained for a period of one year following completion of the master's program. If you wish to contact either the researcher or the thesis advisor, addresses and phones are listed below.

I know our time is precious, but it should take less than 30 minutes to answer the questions, and the return postage is prepaid. Your response is valuable information to the profession, both to contribute to nursing's knowledge of empowerment, and to help discover what the state of empowerment is for the rural or urban nurse in Montana. And, your response is very valuable information to me, a graduate student at Montana State University College of Nursing, as part of my thesis project.

Results of the study will be compiled by computer at the University of Montana, and return of the questionnaire will serve as your consent to participate in the study. You may refuse to participate simply by mailing the enclosed stamped envelope back empty. If desired, you may retain this letter for your own interest or records. For your time and assistance, I am most grateful.

Sincerely,

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