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


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.

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of the requirements for the degree

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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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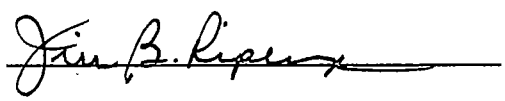
Signature 

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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.

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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.

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# 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

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 bureacratic 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

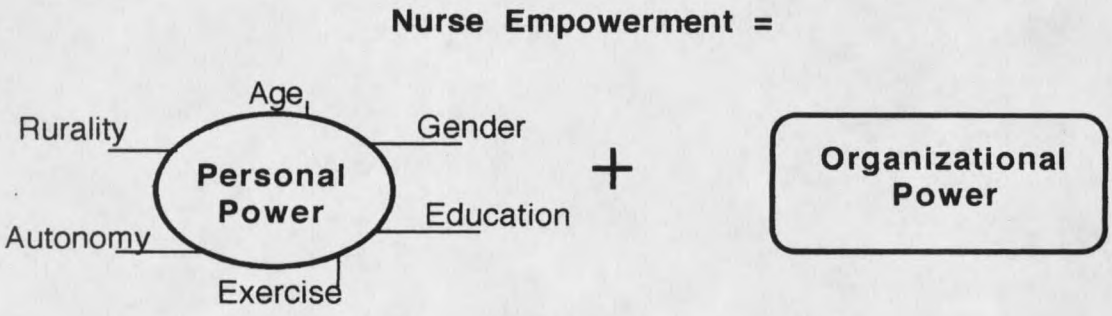
This study addresses the following questions: Is there a difference in personal empowerment between rural and urban nurses? Is there a difference between rural and urban nurses in organizational empowerment? Is there a difference in rural and urban nurses across the variables of age, gender, education, 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




(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 catgories 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 signficant 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.

# CHAPTER 3

# METHODS

## Sample

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.