ADULT LIFE CRISES, SEXISM, AND MORAL REASONING IN FEMALE NURSES

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CHAPTER 1

INTRODUCTION

Ashley's (1976) historical survey reveals the climate and practice of paternalism and sexism in the health care system in the United States. Styles (1982) speaking to the 75th Anniversary Texas Nurses Association Convention iterated the position of nurses in Texas.

> For 75 years we have been neither slave or master. Not slave because our freedom was always there for the taking; not master, because we always paused to debate ourselves or to beseech others. Our bondage is only to ourselves, forged through our failure to understand, or to accept, or to unite behind our calling. (p. 14)

Styles challenged nurses to close the gap between what the nursing profession is and what it should be, using political action as a means.

One wonders why this continued admonishment is necessary. Do male-dominated professions have to be threatened with continued subservience or extinction to rally to self-interested action? Are nurses deterred from acting professionally only by imposed limits from other professions or do the nurses impose the limits themselves? Friedan (1963) reported finding that women

often perceive three sexes: men, other women, and themselves. Is this attitude one that deters nurses' uniting into a cohesive group of professionals?

In a seminal work, Sheehy (1974) described the predictable crises an adult encounters between the ages of 18 and 50 years. Differences in the step-wise progression of men and women raise many questions related to personal development and others related to professional life. Do nurses become "locked in" early in their careers as caregivers and accept a role of taking care of others without expecting much in return, much as mothers? Does a profession have a similar process of development to reach maturity necessitating that a majority of its members move through the steps similarly? Although Sheehy (1974) did not relate this story of adult development directly to moral reasoning, changes in attitude, goals, and social consciousness are mentioned and may be comparable to stages in moral development.

Recent research in moral reasoning among nurses has shown that nurses function mainly at the rule-governed (Stages 3 and 4) level of Kohlberg's model of moral development (Ketefian, 1981b; Murphy, cited in Ketefian, 1981a). Is continued functioning at a lower level of moral reasoning in terms of intellectual development

related to sexist attitudes or to passages through life's crises experienced personally or professionally?

Problem of Study

The problem of the study was to determine whether the decisions made by female, American born, registered nurses have a consistent pattern across personal, professional, and moral conflict situations at different adult life crisis points. The association of personal characteristics, including sexist attitudes, with the pattern of decision making was a part of the problem.

Justification for the Study

In the Editor's statement prefacing the volume on "Ethics and Values" of Advances in Nursing Science, Chinn (1979) stated "the problems of ethics and values are inherent in all nursing acts . . . critical and rigorous establishment of a body of knowledge concerning ethics and values needed" (p. vi). It is significant that this issues was the third in the series of this important nursing journal, following only the two issues on practice oriented theory.

Jameton (1977) described the study of nursing ethics as different from medical ethics, involving "a variety of

ethical problems either unique to the profession or significantly modified by it" (p. 22). The uniqueness was related to nurses' "subordinate position in the health care hierarchy and their complex role" (p. 22). This subordinate position raised questions of personal power, responsibility to decision-making power ratio, and the distribution of labor in the health care setting. The complex roles of the nurse included

> patient advocate, aide to the medical profession, hospital staff worker or administrator--as well as nursing professionals . . . raising a host of ethical problems related to autonomy, coercion, role conflict, and personal identity (p. 22).

while advocating a philosophic orientation to providing health care to "holistic" man. Jameton surmised that "feminist analyses of autonomy and self-concept can help to explain and to change patterns of decision-making in health care" (p. 22), relating to roles and responsibilities of nurses and other professionals in the settings.

This picture of nurses' ethical situation in health care settings resembles the situations described by Goodman (1979) in portraying the life changes of 150 people in the popular book Turning Points. Sex role attitudes, role expectations, individual growth and desires, and other circumstances were examined by those

who changed their lives by their own action. How does this examination relate to nurses and nursing practice? What effect does individual growth have on one's expectation of practice and one's actual practice as a nurse? Are passive recipients of change affected significantly by the change?

This study was designed to provide some insight into the questions of association between individual life experiences and decisions related to growth, sex role attitudes, and moral reasoning in female nurses.

Conceptual Framework

Krampitz and Pavlovich (1981) defined a conceptual framework as a "loosely conceived and often broadly based organization of phenomena . . . but the formulation of propositions that state a relationship between concepts is missing" (p. 20). The conceptual framework for this study is broadly based, from the philosophy of Wittgenstein (1969, 1974) to the current speculation of passages through life crises in adult life of Sheehy (1974), but hopefully with sufficient rationality to clarify the thought processes suggesting the associations under study. In discussing usage of theoretical terms, Kaplan (1964) stated parenthetically that "'lunch' and 'dinner' do not identify dishes, but the circumstances of

the eating" (p. 60), which seems germane to determination of conceptual or theoretical nature of research frameworks.

The approach is phenomenological, deriving from Wittgenstein (1969, 1974) who reportedly was influenced by Kant, Husserl, Merleau-Ponty and others of the Vienna Circle of the early twentieth century (Gier, 1981). The concepts derived from Wittgenstein are the Lebensformen, life forms, and the associated language-games. The theory of moral reasoning of Kohlberg (1981) is described as a special case of Lebensform. The concepts of levels of moral reasoning and developmental processes expanded from Piaget (Kohlberg, 1981) were selected for inclusion. Sheehy's (1974) conceptualization of passages in adult development is deemed comparable to moral development. Consideration of differences between men and women in passage through life crises raises questions about generalizability requiring further investigation.

Wittgenstein's Philosophy

Gier (1981) discussed the

> Concept of Lebensformen in terms of four levels: (1) a biological level from which (2) unique human activities like pretending, grieving, etc. are then expressed in (3) various cultural styles that in turn have their formal ground in a (4) generally

> sociolinguistic framework (Wittgenstein's Weltbild). (p. 20)

The notion of a framework is important in indicating the formal nature of Lebensformen and including language within the structure.

At the biological level there are necessities for participating in Lebensformen. Speech ability, hearing, sight, and other senses are involved. Memory is requisite to learning language. Once the biological necessities are attained, the language can be learned and life forms participated in. Animals are excepted due to some deficiencies in memory and language-related abilities.

The concept Lebensformen contains

> The formal framework that make society and culture possible . . . having no explanatory power, but being the givens used in explanation of the meaning of life and the concepts humans use. (Gier, 1981, p. 31)

The life forms cited include hoping and pretending, being certain, praying, obeying, and having a language in general. Wittgenstein does not explain Lebensformen extensively, so there are differences among philosophers as to the exact meaning.

Being certain is discussed in many of Wittgenstein's works, particularly Uber Gewissheit, On Certainty (1969). How does one become certain? What is the difference in knowing and believing? What should one

doubt? What criteria does and should one use to determine whether another understands one's meaning and whether one's understanding is representative of reality? These questions must be posed and answered within different language-games. In mathematics, formal rules exist (have been developed by language-using humans) that dictate procedures for proof with formal definitions of the terms accepted and used within the confines of the grammar of mathematics. In primitive languages, the rules are less explicit, developing over time with repeated use of the language elements.

Wittgenstein (1969) used the analogy of understanding how to play chess and some ball games to clarify. Does one know how to play chess when he knows all the rules or is knowing how dependent on playing the game? One has to be able to play to show understanding of the rules and the game (Wittgenstein, 1969). Tennis has rules governing most aspects of play, but how does one know how hard or how high to hit the ball to be successful? To play a language-game one must know the rules and "the background context of a form of life" (Kenny, 1973, p. 166).

This background context includes questions related to whether words or sentences contain the meaning,

whether "use" means "usage" or "utility"; and whether the surface grammar reveals the depth grammar. Kenny (1973) stated what he thought would be Wittgenstein's answer to these questions as:

> That one gives the use of a piece of language by describing its role in a language-game and that a language-game is a more or less complicated sharable human activity which might, or might not, have a utility which could be grasped and stated outside the game. (p. 168)

Wittgenstein (1974b) defined meaning as "what an explanation of meaning explains" (p. 69). He clarifies meaning further in the following:

> When we study language we envisage it as a game with fixed rules. We compare it with, and measure it against, a game of that kind.
>
> If for our purpose we wish to regulate the use of a word by definite rules, then alongside its fluctuating use we set up a different use by codifying one of its characteristic aspects. Thus it could be said that the use of the word "good" (in an ethical sense) is a combination of a very large number of interrelated games, each of them as it were a facet of the use. What makes a single concept here is precisely the connection, the relationship, between the facets. (p. 77)

In the single extant work devoted to ethics, Wittgenstein (1974a) stated "our words used as we use them in science, are vessels capable only of containing and conveying meaning and sense, <u>natural</u> meaning and sense. Ethics, if it is anything, is supernatural" (p. 411) in clarifying a difference between the relative

judgments of normal language and thought and the absolute judgments of value in ethical (philosophical) language and thought. When one feels the sensation of insignificance and awe when viewing the stars on a clear night, that sensation cannot be expressed. When a miracle is examined and dissected to explain what it is, it is no longer a miracle. Any statement of fact cannot be considered as ethical (p. 410). "Ethics so far as it springs from the desire to say something about the ultimate meaning of life, the absolute good, the absolutely valuable, can be no science," concluded Wittgenstein in the discussion of the limitation of language relating to ethical philosophy and discussion. For this study, ethics, or moral reasoning, will be considered as a language-game within the Lebensform of being certain and as essential to human existence.

From this brief discussion, the concept of Lebensformen relates to a language-game having structure decided by language users who are related culturally and socially. Meaning of a concept as a unit of language may vary in different social settings and language-games. A complete understanding (certainty) of meaning requires knowing the rules of a language-game and practice to

determine the interrelatedness among the uses in various language-games.

Kohlberg's Theory of Moral Reasoning

Just as meaning can be understood from determining use in various language-games, moral practices can be determined from surveying moral behavior, but the question remains whether that which is practiced is what ought to be practiced. Kohlberg (1981) discussed his efforts to avoid this "naturalistic fallacy," deriving ought statements from is statements.

Two assumptions commonly accepted by philosophers relating to ethics were considered by Kohlberg (1981) to be erroneous. First, the assumption of cultural relativity of moral values was questioned since some ethical principles, i.e. value of human life, prevail cross-culturally.

Secondly, the "process assumption that morality and moral learning are fundamentally emotional and irrational processes based on mechanisms of habit, reward and punishment, identification, and defense" (p.106) was questioned.

Kohlberg (1981) described the theory as cognitive-developmental, meaning that "there is a sequence of moral stages for the same basic reasons that there are

cognitive or logicomathematical stages" (p. 133). The concept of stages of Kohlberg "implies something more than age trends" (p. 120). Stages implied invariant sequences, defined "structured wholes" of moral reasoning, and implied universality of sequence under varying cultural conditions.

Kohlberg's (1981) assumptions were that:

> (1) stages of moral development representing (2) cognitive-structural transformations in conception of self and society. . . ., and (3) that these stages represent successive modes of taking the role of others in social situations, and hence that (4) the social-environmental determinants of development are its opportunities for role taking. . . . (5) an active child who structures his or her perceived environment, . . . (6) moral stages and their development represent the interaction of the child's structuring tendencies and the structural features of the environment, leading to (7) successive forms of equilibrium in interaction. This equilibrium is conceived as (8) a level of justice, with (9) change being caused by disequilibrium, where (10) some optimal level of match or discrepancy between the child and the environment is necessary for change. (p. 134)

In the most recent listing of stages (1981), there are three traditional levels, with Level B/C added as a transitional level. Level A, the Preconventional Level, is individualistic. Stage 1 is egocentric where right is obedience and avoidance of punishment. Stage 2 is concrete individualistic where right relates to serving one's own needs and to making fair deals.

Level B is the Conventional Level where interpersonal and societal expectations are more pervasive. Stage 3 includes a shared perspective with other individuals, with right being concerned about other people and their feelings and being a good or nice person. Stage 4 focuses on the society as a system over the individual and right has to do with maintaining society through performance of one's duties to society and social order. Level B/C, the Transitional Level, is "postconventional but not yet principled" (p. 411), where the individual stands outside society to consider himself but there is not commitment to society as a whole. Kohlberg numbered this Stage 4-1/2.

Level C, the Postconventional or Principled Level, involves rights, contracts, and universal ethical principles. Stage 5 integrates awareness of values and rights prior to social attachments, and right behavior is upholding the basic rights, values, and contracts of society. Stage 6 moves to a moral point of view with individuals recognized as ends, not means. The right is determined by universal ethical principles, and the validity of these principles is the rationale for moral decisions and actions.

Kohlberg reasoned that the higher stages are better than the lower because of the complexity and inclusiveness. An individual will act at one stage principally, but may be in transition from that stage to a higher stage, using the higher at some times. One cannot understand the reasoning of those more than one stage higher, but can understand and explain why lower stages are not presently utilized or acceptable.

Development of higher stages of moral reasoning is dependent on cognitive development and on having the opportunity and the expectation from past experience to progress toward the higher stages. Modal behavior or stage-in-use of the models available to learn from and aspire to will influence the stage of the individual.

For this study, moral reasoning is considered a language-game with rules determined by the society and culture of the individual, increasing in complexity with societal and individual development. The background context of factors influencing participation includes the subculture within society, the individual perception of the meaning of the rules, and personal relationships to the language-game and to society. This concept of background context provides the framework for including

Sheehy's (1974) hypotheses of passages through life crises in adulthood.

Sheehy's Hypotheses of Passages

The objectives of the work were "to locate the individual's inner changes . . . , to compare the developmental rhythms of men and women . . . , and to examine the predictable crises for couples" (Sheehy, 1974, p. 15). The 115 subjects included "pacesetters--healthy, motivated people who either began in or have entered the middle class" (p. 16). The works of Levinson, Mead, and Gould were cited as contributing to the ideas and progress of the analysis (Sheehy, 1974, p. xiii).

Throughout the passages, perception of four areas of living is altered--the interior sense of self in relation to others, the proportion of safeness to danger in one's life, time, and the sense of aliveness or stagnation. The passages were termed Pulling up Roots, the Trying Twenties, Catch-30, Rooting and Extending, Deadline Decade, the Midlife Passage, and Renewal. As with Levinson's (1978) study, there may be overlap and change in tempo by "untimely events" and "life accidents" that affect the timing of the passages. Rarely, excepting these unforeseen events, does a crisis occur abruptly,

simmering until there is sufficient force to raise the lid.

In Pulling up Roots, occurring from 18 to 22 years, primary concern lies in developing peer group and sex roles, in developing one's occupation, and in clarifying one's world view. By the Trying Twenties (ages 22 to 28) one focuses on taking hold of the adult world with many feelings of "I should be--working for something; married by now; helping others; trying out new things; etc." (Sheehy, 1974, p. 86). A conviction of rightness and permanence of one's decisions prevails.

Catch-30 occurs with "a vague but persistent sense of wanting to be something more" (p. 138) around ages 28 to 32 years. The urge for broader involvement and interest threatens the need for safety. All aspects of life require reexamination--marriage or singleness, occupation, social contacts and contracts, even religion. A willingness to change is prerequisite to growth. The later years of the 30s, spent in Rooting and Extending, involve settling into the chosen course--the house, the spouse, and the professional climb toward whatever goal.

> Somewhere between 35 and 45, if we let ourselves, most of us will have a full-out authenticity crisis . . . in those gut-level perceptions . . . leading to a recognition of our mortality and that life is about one-half over. (Sheehy, 1974, p. 242)

Men's change in sense of time is more related to career position and their health, while women may be invigorated to open new vistas. There is a reintegration of the self to an identity that is truly one's own. Denial or repression of the inner turmoil of this crisis inhibits further growth by restricting one's view of self. Sheehy (1974) admonished people to: "Let Go. Let it happen to you. Let it happen to your partner. Let the feelings. Let the changes" (p. 251).

Renewal, the middle age, has the virtue of experience and "two of the most salient characteristics of the mature years: Insightfulness and philosophical concern" (p. 349). Emphasis on career position and health changes predominate with men, while women relate to timing of family events. Attitudes to money, spiritual life, and to death may change and eccentricities develop.

Life patterns of women were described as related to past choices. The patterns described are common. Sheehy (1974) reminded the reader that one can change one's mind and of the impact of unilateral change in any close relationship. The patterns are:

> Caregiver: A woman who marries in her early twenties or before and who at that time is of no mind to go beyond the domestic role.

Either-Or: Women who feel required in their twenties to choose between love and children or work and accomplishment. There are two types:

Nurturer Who Defers Achievement: She postpones any strenuous career efforts to marry and start a family. But unlike the caregiver, she intends to pick up on an extrafamilial pursuit at a later point.

Achiever Who Defers Nurturing: She postpones motherhood and often marriage, too, in order to spend at least six or seven years completing her professional preparation.

Integrators: Women who try to combine all in the twenties--to integrate marriage, career, and motherhood.

Never-Married Women: Including paranurturers and office wives.

Transients: Women who choose impermanence in their twenties and wander sexually, occupationally, and geographically. (p. 206)

Progression through passages entails risk. Those possessing open minds, enough sense of self, and a willingness to change experience the risk as opportunity for growth and grow with each passage (Sheehy, 1974). The insecure may become "locked in" to early decisions and invest energy in maintaining their position, not in expanding, at the cost of superficiality throughout adult life. Growth through the passages seems to parallel development of moral reasoning through the stages. Do women who commit themselves to a life pattern and deny

reconsideration become locked into lower levels of moral reasoning as they do to superficiality of existence?

In summary, the problem derived from these philosophical and theoretical perspectives was concerned with whether decisions made by female nurses have a consistent pattern across situations at different crisis points in adult life. Are personal, professional, and moral decisions within the same language-game or different? Is progress through developmental stages determined by individual decision, as modulated by past decisions; sense of self as women, professional, and in relation to others (spouse, mother, etc.); the occurrence of life accidents or untimely events such as divorce or death of a close relative; and/or the reality of the life situation?

Assumptions

The following assumptions were accepted for this study:

1. Meaning of a concept expressed through language is a function of culture and society.

2. Meaning of a concept varies between language games.

3. Intellectual development precedes moral reasoning development.

4. Values and attitudes are culturally determined and will affect decision making.

5. Decision-making process can be determined from examination of past decisions and hypothetical situations.

Research Questions

The following questions guided the design of the study and the analysis of data.

1. What patterns of decisions are utilized by female nurses?

2. Do patterns of decisions differ across adult life crisis points in individuals?

3. Do the patterns of decisions differ between those with high sexist attitude scores and those with lower scores?

4. What is the association between patterns of decisions and stage of moral reasoning?

5. What patterns of personal characteristics are associated with the stages of moral reasoning?

Definitions of Terms

For the study, the following definitions were accepted.

Patterns are composites of traits and/or recurrent decision types characteristic of the individual subject.

Adult life crisis points are the predictable periods of change described by Sheehy (1974) occurring from 18 to 22 years, 22 to 28 years, and 28 to 32 years of age.

Personal characteristics composing the background context for decision making include age, marital status, ethnicity, experience in family of origin, professional status, range of life experiences, roles, and religious life.

Sexist attitudes are the "attitudes which function to place females in a position of relative inferiority to males by limiting women's social, political, economic, and psychological development" (Benson & Vincent, 1980, p. 278). Sexist attitudes are a part of background context, but are measured separately. The quoted definition was utilized in development of the Sexist Attitudes Toward Women Scale (SATWS) which will be used as the measure of sexist attitudes in this study.

Stage of moral reasoning is the relative developmental progress as described by Kohlberg (1981). Analysis focused on the reasoning process in evaluating the options on the Judgments about Nursing Decisions (JAND)

developed by Ketefian (1981b) and the personal experience of the subjects.

Limitations

The limitations of this study were:

1. The phenomenological method with a small sample size limits generalization to the study sample.

2. The skill of the researcher in determining associations may limit the scope of the findings.

Summary

In this Chapter the problem of the associations between patterns of decisions, personal characteristics, sexist attitudes, and stage of moral reasoning has been explored. The conceptual framework for inclusion of these variables was presented. The study variables have been defined and the limitations to generalizability iterated. Chapter 2 includes the review of literatrue relevant to the problem of the study.

CHAPTER 2

REVIEW OF LITERATURE

The ancient injunction "Know Thyself" bespeaks concern for understanding human nature and behavior. Extant classical Greek works and the Holy Bible which have influenced western philosophy and society contain statements of the inferior position of women and imply a mean, conniving nature.

In The Republic, men were called the "guardians and watchdogs of the herd." Discussing the nature and position of women in the ideal state, Socrates concluded that:

> And if so, my friend, I said, there is no special faculty of administration in a state which a woman has because she is a woman, or which a man has by virtue of his sex, but the gifts of nature are alike diffused in both; all the pursuits of men are the pursuits of women also, but in all of them a woman is inferior to a man. (Plato, The Republic, Book V, p. 455)

These notions of women's inferiority and different nature from men persist as sexist attitudes. As has been noted by many, happy slaves do not revolt, so women have been encultured and educated to believe and accept these notions and the associated position in society until

recently. This review includes a survey of the recent popular and research literature on the concepts of passages through adult life crises, sexist attitudes and the effects on woman's progress, development of moral reasoning, and nursing as a female-dominated profession.

Passages Through Adult Life Crises

The term passages, used by Sheehy (1974) as a "less loaded word [than Crisis] for the critical transitions between stages" (p. 16) of adult development, connotes a movement through space and time. Frenkel-Brunswick, Erickson, Mead, and Levinson were cited as influencing Sheehy's development of the concept passages.

Frenkel-Brunswik (1968) reported findings of a study conducted with Buhler of a 400-person sample composed of broad cultural, social, age, and occupational ranges. Data utilized included interviews, letters, and other records of import to the person's life. The study was conducted in Vienna in the 1930s. The data were examined for: external events including the dimensions of life, internal reactions to these events, and the accomplishments and productions of life.

Five biological periods were described with the middle period, ages 25 to 40, being horizontal between

periods of ascent and decline. Marker events were related to sexual development and performance. Similarly five behavior periods were described with the middle period, ages 26 to 50, having the largest number of dimensions of life. "The transition to the fourth phase is marked by psychological crisis" (p. 80) with a shift in focus from one's own needs as uppermost to "the duties directed by our ideals and our conscience, or laid down by authority and practical demands" (p. 83).

In summary, Frenkel-Brunswik (1968) listed two important developmental laws: "transference of dominance" meaning the change of emphasis from needs to duties, and "the gradual specification of interests" meaning clarification of one's goals or objectives in life and perfecting skill in goal-directed activity (p. 83). The prerequisites cited for success in life were "the ability to transpose oneself, to take on another attitude toward life" (p. 84).

Erikson (1963) formulated a theory of personality development encompassing eight stages of ego development, with developmental crises at each stage, extending throughout the life span from infancy through late adulthood. Of particular interest for Sheehy and this study are the stages of early and middle adulthood--

intimacy versus ego isolation and generativity versus stagnation. As with all developmental theories, one's experience in previous stages will affect one's perception of and reaction to a present crisis, i.e., if trust was not established in infancy, intimacy may not be possible in early adulthood.

Intimacy, a sense of mutuality with a loved person of the opposite sex, was related not only to psychosexual development, but also to procreation, recreation, and vocation. In Childhood and Society, Erikson (1963) stated:

> In this book, the emphasis is on the childhood stages, otherwise the section on generativity would of necessity be the central one, for this term encompasses the evolutionary development which has made man the teaching and instituting as well as learning animal. (p. 267)

Productivity and creativity were cited as popular synonyms, but as insufficient to explain generativity.

In a later lecture, Erikson (1964) clarified the development of virtues, defined as "certain human qualities of strength" (p. 113). The virtues discussed were "Hope, Will, Purpose, and Competence as the rudiments of virtue developed in childhood; of Fidelity as the adolescent virtue; and of Love, Care, and Wisdom as the central virtues of adulthood" (p. 115). Of the adult virtues,

Love, defined as "mutuality of devotion forever subduing the antagonisms inherent in divided function," (p. 129) was cited as the greatest of human virtues. According to Erikson, biological differences between men and women in young adulthood result in "a polarization of the two sexes within a joint life-style" (p. 129). This polarization was defined as a "mutual enhancement of experience and of distribution of labor within a stylized pattern of love and care" (p. 129).

"Care is the widening concern for what has been generated by love, necessity, or accident; it overcomes the ambivalance adhering to irreversible obligation" (Erikson, 1964, p. 131). Erikson included under Care, the stage of generativity with a sharing of one's accumulated knowledge, skills, and self to perpetuate society.

Wisdom requires individuality, guarded by the "ego," with perogatives of "a sense of wholeness, a sense of centrality in time and space, and a sense of freedom of choice" (Erikson, 1964, p. 148). Wisdom was defined as "detached concern with life itself, in the face of death itself" (p. 133). Erikson spoke of two concurrent life cycles--one generation concluding in the next and one individual life coming to a conclusion. Wisdom was further explained as the "essence of knowledge freed from

temporal relativity" conveying experience, responding to on-coming generations to give an integrated heritage, yet remaining aware of the relativity of knowledge (p. 133).

Combination of the theory of ego development with virtue development adds to the generalizability of Erikson's formulation. The ethical considerations will be discussed in the section of this Chapter on moral reasoning.

Sheehy (1974) called Margaret Mead "the quintessential woman achiever" (p. 228). Mead's anthropological works may have influenced Sheehy's description, but the recounts of personal association show a different influence. Mead was also termed "the General among the foot soldiers of modern feminism" exemplified by designing "a life that would not make a woman a prisoner of her sex or of her age" (p. 229).

Levinson, a student of Frenkel-Brunswik, advised Sheehy in the method of biographical investigation (Sheehy, 1974, p. 14). Levinson (1978) discussed the life cycle as having a particular character and a basic sequence. The character included the idea of seasons, qualitatively different periods or stages, having infinite variations. The sequence related to the process or journey "from birth to old age following an

underlying, universal pattern on which there are endless cultural and individual variations" (p. 6).

The sample in Levinson's study contained 40 men aged 35 to 45 years, the mid-life decade. The sample was delimited to one sex, the narrow age range, and four occupational subgroups to attain maximum specificity of the findings. The subjects varied on "social class origin, racial-ethnic-religious origin, education, and marital status" (Levinson, 1978, p. 12).

Levinson (1978) determined that the life cycle is composed of "a sequence of eras each lasting roughly twenty-five years" (p. 18). Each era has a distinctive character of living, including biological, psychological, and social aspects. Within the eras was found an alternating series of stable periods and transitional periods. The stable periods, lasting 6 to 8 or possibly 10 years, were cited as having the primary task of building a life structure--"a man must make certain key choices, form a structure around them, and pursue his goals and values within this structure" (p. 49). Examination of the individual life structures was centered on the choices the subjects made and the manner of dealing with the consequences. Major choices had to do with marriage and family and with occupation.

The primary tasks of the transitional periods were described as unique to the place in the life cycle, involving questioning and reappraising the existing structure, exploring possibilities for change in oneself and one's world, and committing oneself to choices for one's future. The transitional periods were processes of separation or loss from parts of the life structure useful at earlier stages, "but under reasonably supportive conditions the process of separation leads to enrichment, differentiation and development of the self" (Levinson, 1978, p. 51). Levinson set the duration for transitions at 3 to 6 years with 4 or 5 years most common.

The era of Early Adulthood shown with stable periods and transitions over a 23-years span included:

17 to 22 Early Adult Transition

22 to 28 Entering the Adult World

28 to 33 Age 30 Transition

33 to 40 Settling Down

The first adult life structure (stable period from 22 to 28 years) was characterized as a "shift in the center of gravity of one's life" to accomplish two antithetical tasks--exploring possibilities for adult living and creating a stable life structure (p. 57). The Age 30 Transition may become a crisis when he responds to the

"voice within the self" asking the man if there is still time to change what he has in life, what he wants in life, and how he experiences his life situation.

The second adult life structure, Settling Down period, was compared to the image of a ladder--all the dimensions of advancement have to be sought. The task was defined as becoming a "full-fledged adult within his own world" defining one's personal enterprise or project as attributed to Sartre (p. 59).

The Mid-Life Transition providing the bridge from early to middle adulthood was described as varying from little impact, to moderate to severe crisis in the lives of the subjects. "During a transition and especially in the Mid-Life Transition--the neglected parts of the self more urgently seek expression and stimulate the modification of the existing structure" stated Levinson (1978, p. 61). Ages 40 to 45 years were included in the Mid-Life Transition. Levinson listed four polarities to be resolved as the principal task at the Mid-Life Transition as: young/old; destruction/creation; masculine/feminine; and attachment/separateness (p. 197). Each of these exists in varying degrees in every man and balance between the opposites must be reestablished for the individual.

The era of Middle Adulthood, which lasts from age 40 to 60 years, included the Mid-Life Transition at the onset and ended with the Late Adult Transition (60 to 65 years). The other periods contained 5-year periods of stability and transition as listed below.

45 to 50 Entering Middle Adulthood

50 to 55 Age 50 Transition

55 to 60 Culmination of Middle Adulthood

Levinson admitted to fewer generalizations about the Middle Adulthood Period. The major task was stated as reevaluating the life structure in relation to one's accomplishments, future probabilities, changing family structure, and individual physical and mental health. Breaking away from old patterns, like getting a divorce, changing jobs, or changing priorities, may provide opportunity for growth within one's personal structure. The man may have to admit that he will never make president or whatever his goal was in his career. He has to decide how to spend the future with this knowledge--change to another company, learn to enjoy the work for what it is, accept that work produces the things he needs and find another source of satisfaction for achievement needs, or find some form of denial or withdrawal of energy to substitute for his goal.

The relative newness of the notion of Middle Adulthood, resulting from the increased life span and affluence of twentieth century Western society, has created a need for understanding of the developmental phases of this period. Levinson (1978) vividly explicated that there is not a calm period between the storms of adolescence and retirement, there is cyclic development through relatively stable and transitional periods in man's life.

Fried (1976) in describing The Middle-Age Crisis cited the main psychological themes of the crisis--identity, death, aging, time, power, and intimacy. In reexamining attitudes toward work and marriage (presumably long-term), Fried stated that

> These second thoughts are bound to be tinged by depression and hostility; and secondly . . . perceived as boring--that is, threatening and conflictfull--because both are especially convenient areas for solving the psycho-social problems attached to the themes of intimacy, power, and identity. (p. 99)

These themes are significant since cultural values must be considered along with personal considerations in any revaluation.

The Middle-Age Crisis was considered as analogous to that of adolescence. Physically, hormone changes take place producing many effects. Psychologically, the middlescent is also "likely to be emotional, moody,

introspective, bored, self-involved, withdrawn, and/or openly hostile and lustful" (p. 147). Socially, there is a search for age appropriate and acceptable roles and commitments. Reference to Erikson's stages led to the conclusion that with a positive outcome of the Middle Age Crisis, one demonstrates "a willingness to accept power and to assume social and personal responsibility during middle life" (Fried, 1976, p. 116).

Goodman (1979) described findings from a survey of 150 men and women focused on observations of changes in their lives related to new attitudes toward sex roles. The term "turning points" was used as "one or another of the pivotal steps that may lead to change" (p. 33). Goodman's emphasis was on change as a process, though not explicitly developmental as in the other works reviewed, with some initiating factor and some psychological component.

Three factors were found to be related to change in the life of adults. A "fait accompli," or accomplished fact, from Allport, was described as an external event or accident which alters one's present life situation (Goodman, 1976, p. 19). These range from divorce or getting fired to financial losses due to floods or

fire. Here, change in oneself is a reaction to an imposed change in one's situation.

A change of ideas, political, philosophical, or religious, could lead to a change of life. Many of the popular self-help publications are predicated on this notion. People found that changing ideas and behavior was easier than changing emotional reactions in their situations. An open mind and recognition of the contradictions one professes could precipitate conflict which makes one susceptible to changing. This notion that one must be willing to reexamine one's perception of self, relationships, and goals was repeated in many works on developing through growth in adult life.

Relating to change in adult life, ambivalence, cited as descriptive of any change, was called the "watchword of the transitional corridor I call the Shuttle Zone" by Goodman (1979, p. 65). The ambivalence was expressed as fears of disruption of the family, fears of submerging the family, and fears of the uncertainty of the future of change (p. 164). As polar opposites in the Shuttle Zone, were listed Change Innovators and Change Resistors, with a majority of middlegrounders between the poles.

Change Innovators were depicted as seeking change, often with the assumption "that they can become instant

new people" (Goodman, 1979, p. 77). The change innovators identified by Goodman sought non-traditional roles and life styles--career orientation over family responsibility for the women. During the adjustment to major change in life style, there were internal "arguments between values of nurturing and achieving" and conversation between the past and future roles (p. 90).

Middlegrounders were described as wanting change without risk, growth without loss, the best of both worlds. The New Double Standard was desired for the benefits of personal life in having traditional roles and for the benefits of independent life through nontraditional roles (p. 131). Goodman (1979) stated that middlegrounders "couldn't and didn't want to avoid change but they did want to control its speed . . . to evolve--rather than revolt" (p. 126).

Change resistors, usually older, were characterized by Goodman (1979) as adhering to the traditional past, fearful of loss, and protective of their investments in past decisions. "These are people who value safety and sameness" (p. 100). Marable Morgan (The Total Woman) and Phyllis Schlafly (The Phyllis Schlafly Report), who both opposed the Equal Rights Amendment, were cited as change resistors.

Goodman suggested that the same ambivalence that exists in modern American society between liberals and conservatives, political parties, and other interest groups is reflected in the individual crises of growth and that resolution of social issues will provide for more choices which could accelerate opportunities for change.

Adults will affect and be affected by group norms in society and will have changing developmental tasks as they grow older. The individual must make decisions at those points where internal conflict demands action--for growth or stagnation. In the next section the impact of the social acceptance of sexism will be discussed.

Sexist Attitudes and Woman's Progress

De Beauvoir (1974) discussed the difference between the concept woman which can be defined by biological criteria and the concept feminine or femininity which is culturally defined. She stated:

> One is not born, but rather becomes, a woman. No biological, psychological, or economic fate determines the figure that the human female presents in society; it is civilization as a whole that produces this creature, intermediate between male and eunuch, which is described as feminine. Only the intervention of someone else can establish an individual as an Other. (p. 301)

In this classic work of women's liberation movements, de Beauvoir revealed the myths and realities about woman's position in society--and the philosophers, psychoanalysts, politicians, authors, and other men who contributed to the construction and continuation of the myths.

Millett (1970) explicated the notion of sexual politics where politics referred to "power-structured relationships, by arrangements whereby one group of persons is controlled by another" (p. 23). American society was called a patriarchy where "every avenue of power within society, . . . is entirely in male hands" with the authority for this position, the ethics and values, and the philosophy and are all male manufactured (p. 25). Any power structure can be maintained either by consent of the subordinated or by violence. Relating to maintenance of the patriarcial environment in contemporary America, Millett (1970) stated:

> Sexual politics obtains consent through temperament, role, and status. As to status, a pervasive assent to the prejudice of male superiority guarantees superior status in the male, inferior in the female. The first item, temperament, involves the formation of human personality along stereotyped lines of sex category ("masculine" and "feminine"), based on the needs and values of the dominant group and dictated by what its members cherish in themselves and find convenient in subordinates:

> aggression, intelligence, force and efficacy in the male; passivity, ignorance, docility, "virtue," and ineffectuality in the female. This is complemented by a second factor, sex role, which decrees a consonant and highly elaborate code of conduct, gesture and attitude for each sex. In terms of activity, sex role assigns domestic service and attendence upon infants to the female, the rest of human achievement, interest, and ambition to the male. The limited role alloted the female tends to arrest her at the level of biological experience. (p. 26)

Arguments against equality of rights for women have raged long--beginning in 1848 at Seneca Falls, New York, with the first women's rights convention agreeing that the Declaration of Independence ought to read "We hold these truths to be self-evident: that all men and women are created equal" (Eisler, 1978, p. 45). The arguments against equal rights have been directed at maintaining the Aristotelian fallacy of natural rulers and others who are naturally to be ruled. Since men gathered together to decide the rules of government and the "right" ways to behave, women have been manipulated to accept the decisions. Religious dogma relegated the woman to give up her family, go with her husband, to obey, and to provide consort for his gratification (Eisler, 1978). Legal sanction followed, even to Blackstone's (1723-1780) comment that the husband had the right to domestic chastisement--legally beating the wife. If a woman was

chattel like slaves and household goods, she could not sue for support or otherwise maintain herself without her husband's permission. Judeo-Christian women have been reminded that Eve was the one who committed the first sin in eating the forbidden fruit and that all women must atone by faithfully serving an earthly husband-master. Women were divided into "good wives" or some category of "bad woman." Household duties and child rearing were the only legitimate careers for women throughout most of human history. There may be influence implied in the adage that "the hand that rocks the cradle is the hand that rules the world" (Wallace, 1881), but real power comes from controlling others which has not been women's work.

Even a cursory review of research reported in daily newspapers, behavioral science journals, and The Psychology of Women Quarterly reveals the continued discrimination against women, by both men and women. Toder (1980) found that inclusion of men in group activities had a significant effect on the sex role attitudes and discrimination against women scores of college students. Women spoke less when men were present, even if committed to the activity. Toder cited Shomer and Centers who report that all male groups with male experimenters had the

lowest profeminist (or highest sexist) scores among a variety of group compositions.

Feldman-Summers, Montano, Kasprzyk, and Wagner (1980) studied credibility of male and female designated authors in influencing opinions of college students. Gender-related bias was found to be related to whether the issue was perceived as male- or female-related and to gender majority in the group when deciding on the issue, as well as the perceived knowledgeability of the authors on the particular issue. Men were more conforming when the issue was male-related and in a group with a majority of males examining the work of a male authority. Men were generally less conforming than women.

It is well documented that women have lower status jobs and receive lower wages than men. Only one-fourth of salaried women in this country make over $25,000 per year according to latest statistics. Continued reports in newspapers confirm the discrimination. However, there were many women who spoke against the Equal Rights Amendment as being destructive to women's "privileged position." The rhetoric of the debate will not be further reviewed; rather nursing as a feminine profession will be considered.

The paternalistic environment in the health care industry was revealed in Ashley's (1976) book Hospitals, Paternalism, and the Nurse. Many of the notions presented extended from the husband-wife situation to the doctor-nurse relationship. Doctors and hospital administrators are mainly male and nurses mainly female, with the males leading and females following orders.

Jacox (1979) called the Winner decision in Lemons vs. the City of Denver "potentially a landmark civil rights case" (p. 4). Lemons and NURSE, Inc., made up of a group of nurses, brought suit under Title VII of the 1964 Civil Rights Act for discrimination in pay on the basis of sex and under the Fourteenth Amendment for segregation of nurses by sex in salary administration. A salary survey of the City of Denver revealed that male workers averaged $1,592.81 (sign painter $1,245 to parking meter repairman $994) starting monthly salary while female workers averaged $1,090.77 with Graduate Nurse I (97% women) receiving $929. Judge Winner commented that:

> We are confronted with a history which I have no hesitancy at all in finding has discriminated unfairly and improperly against women . . . I think they (the nurses) have established that by and large male dominated occupations probably pay more for comparable work than is paid in the occupations dominated by females. (Jacox, 1979, p. 4)

Yet the judge concluded that comparison of nurses to non-nurses was not the intent of the laws but could lead to a disruption of the American economy and ruled for the defendants (U. S. 10th District Court, April, 1978).

Ashley (1980) in describing the effects of misogyny (woman hating) on nursing cited "nurses' attachment to and involvement with the cult of 'true womanhood'" as the source of degradation of the nursing profession (p. 13). The cult of "true womanhood" was defined as "serving, pleasing and seeking approval of males" which serves to keep nurses powerless and politically impotent (p. 13). The nurse was characterized as manipulated into becoming a "token torturer" of other women, performing painful and unpleasant procedures and acting as co-conspirator for misogynous physicians (p. 17). The nurse who fulfilled the role expectations of "true womanhood" was rewarded with praise and perhaps other "token but subversive gains" but no real autonomy or authority was allowed. Ashley argued that nursing will not progress without nurses embracing feminist attitudes and rejecting the notion of other women being separate but unequal to themselves and men.

In an essay defending the traditional nurse role for the hospital nurse, Newton (1981) argued that the logical

role for the nurse was "the traditional ideal of the skilled and gentle caregiver, whose role in health care requires submission to authority as an essential component" (p. 348). The physician must make the decisions about patients' needs and care because of their "esoteric knowledge" and their licensure to do so (p. 350). The administrator must enforce bureaucratic rules and procedures to maintain order and efficiency in the institution. Ergo, the nurse must be subservient and bring the emotional benefit of mothering and care-taking to patients to humanize an otherwise "moral monstrosity, coolly and mechanically dispensing and disposing of human life and death" (p. 353).

Newton, a professor of philosophy, differentiated an autonomous person, self-determining in all major choices, and an autonomous role, one structured so that the occupant is self determining. To Newton (1981) the traditional nurse, like housewives and slaves, could be an autonomous person, but the role of the nurse could not be autonomous. The autonomous role was described as including "objectivity in judgment, suppression of emotion, and independent initiative in action," (p. 354) which has traditionally been attributed to men. Newton suggested that inclusion of more men in the profession would be

advantageous in overcoming the stereotype of nursing as feminine. This suggestion seems to refute the argument that traditional nurses are needed to deliver care.

As recently as 1965, a doctor described the perfect nurse: "She must feel like a girl, act like a lady, think like a man and work like a dog" (Pratt, 1965). This implies that Victorian notion of a lady, one who knows and keeps her place, coupled with knowing how to think objectively like a man when the occasion requires such thought. Efforts of nurses to develop independence in nursing practice and autonomy for individual practitioners have not been rewarded. The National Joint Practice Commission (NJPC) was initiated on recommendations of the Lysaught reports (Lysaught, 1970) to "discuss and make recommendations concerning the congruent roles of the physician and the nurse in providing quality health care" (p. 89) in 1972 with representatives from the American Nurses Association (ANA) and the American Medical Association (AMA). Lee (1980) reported that the demise of the NJPC was attributed to "very headstrong nurses . . . who wanted to establish practice of nurse practitioners totally unrelated to physicians" as stated by Ritter of the AMA. Lovell (1981) concluded that:

> The medical profession's notion that wives, nurses, and women patients are available to be

> used and abused by medical men was distilled from the teachings of now defunct economists and philosophers who influenced medical ideas during the 1840's when medicine attempted formal organization. (p. 27)

These uses and abuses persist from a patriarchal mentality and a fear of losing control of medical practice as a business and professional territory.

Women as patients have suffered from being endowed with disease labeling for normal physiological events. Pregnancy, menopause, and other reproduction-related functions have been transformed to disease categories (MacPherson, 1981). Psychoanalytic theory makes women the victim of intrapsychic forces on the one hand and the generator of conflicts and inadequacies in their offspring (de Beauvoir, 1974). Women are more likely to have tranquilizers prescribed, to have sterilization procedures, and to have incomplete explanations of their condition than men when getting medical care. Rape and physical abuse victims have often been accused of provoking the attacks and have been treated with less concern than victims of other types of attack.

Since 1903 when Dock (cited in Aikens, 1924) criticized the profession of nursing for showing no leadership in social policy relating to health, nurses have been reminded of their responsibility. In 1908,

Dock chastized the ANA Convention members for failing to support the suffrage movement. Heide, a nurse and ex-president of the National Organization for Women, was cited as stating that the problems of nursing are symptoms of the oppression of women. The leaders of the women's movement cited nursing as a prime example of sex discrimination and encouraged intelligent, capable women to be physicians, dentists, and scientists (Kjervik & Martinson, 1979).

The pleas for nurses to become aware of the problems both within the profession and for women as patients or clients due to the sexists, paternalistic, or misogynous attitudes and practices are increasing. Resistance from within the profession, from physicians and hospital administrators, and the general public which adheres to the myths of nurses' and women's subservience will require affirmative actions for the profession and its members to progress.

Moral Reasoning

As Wittgenstein (1974) cautioned, discussion of ethical decisions and actions may be imprecise. The terms ethical and moral are often used interchangably outside those philosophers who study ethics. Ethics was defined as "the philosophical thinking about morality,

moral problems, and moral judgments" (Frankena, 1973, p. 4). Ethical questions were related to judgments of moral obligation or moral value in the actions and interactions of people by Frankena (1973). Moral obligation concerned what one "ought" to do and moral value what makes one a "good" person. Nonmoral judgment was related to impersonal value judgments or obligations. The justifications for moral decisions were categorized as teleological or utilitarian relating to the resultant nonmoral value or "greatest general good" or as deontological, including intuitionist or existential, relating to accepted rules or principles of action regardless of the nonmoral value of the consequences.

Beauchamp and Childers (1979) cited "ethics as the systematic examination of the moral life" (p. X) exercised through examination and reexamination of ordinary actions, judgments, and justifications. Levels of moral justification were described as "judgments about what ought to be done in particular situations are justified by moral rules, which in turn are grounded in principles and ultimately in ethical theories" (p. 5) by Beauchamp and Childers (1979) in discussing biomedical ethics. For the study, moral reasoning was considered to be the deliberative process of selecting the appropriate action

in a situation of moral conflict, with ethics being the consideration of the justifiability of the selected action.

Kohlberg (1981) stated that "moral principles prescribe universal human obligations" (p. 111) without explaining the derivation of the moral principles from ethical theory. The utility of prevailing moral rules (principles) in guiding moral decisions was questioned by Frankena (1973) since the rules are:

1. "Never very precise, always admit of exceptions, and may come into conflict with one another" (p. 13),

2. "Generally literal, negative, and conservative, not affirmative, constructive, creative, or adaptable to new situations" (p. 14), and

3. Variable from culture to culture.

The problem of defining the types and content of rules has led to even greater problems in research to explore or explain the relationships between components of moral decisions and moral behavior. Graham (1972) recognized three aspects of moral development--the cognitive, the affective, and the behavioral. The cognitive aspect was related to knowing, thinking, and judging, which in moral questions involved knowing the moral rules, their origin and interrelatedness; the capability

of applying a general principle to a particular situation; and deciding on the merits of alternative actions considering the act itself and the probable consequences. The affective aspect referred to "the kinds of feelings we have in relation to actions which we consider right or wrong--in particular, to feelings like anticipatory anxiety, guilt, remorse and shame" (p. 12).

The behavior aspect indicated the overt behavior, the performance of actions deemed to be "right," not merely the avoidance of wrong acts or attempts to reconcile the effects on others of wrongful acts. Graham (1972) surmised that "those with the highest level of moral judgment, for example, should, in general, also be those who act in the most moral way" (p. 13). Agreement was expressed with the earlier findings that inconsistency of moral behavior "results in part from the mitigation of the effects of morally relevant characteristics by other variables" which could be identified by observing individuals in different situations of moral conflict (p. 16).

Lefebvre (1980) presented findings from a study comparing the ethical stance (cognitive aspect) of Americans and recent immigrants from the Soviet Union, utilizing responses to opposing pairs of statements as the

measure of acceptance of compromise or confrontation. The hypothesis was that there were differences in normative behavior between the cultures which "do not belong to or necessarily characterize any single individual, but rather, they are predetermined by a national culture of the country where a person is born and raised" (p. 86).

A logical derivation of the axioms of the two ethical systems was presented showing that the Soviet subjects would not compromise over conflict with another person but would compromise over "bad means" to reach a "good end," while Americans would compromise over conflict with another person but not over "bad means" to reach a "good end." The axiom system was defined in terms of Boolean algebra to test for logical consistency and accuracy. The sample of Soviets was small (14) so there is limited confirmation of the finding that the first axioms were substantiated including the process of reflexion (knowing whether one's perception of self and others is accurate) as a part of the implication process in Boolean algebra.

Kohlberg's studies revealed a similarity of stages in cultures other than American in the development stages of moral reasoning, particularly in Taiwan, a Malaysian tribal village, and in a Turkish village (Graham, 1972,

p. 237). Preliterate societies did not develop to the last two stages. Interestingly, middle-class American children progressed more rapidly than working-class children, but the effect of reading and verbal ability had not been controlled.

Erikson's (1964) description of the virtues of adulthood raised the question whether Love, Care, and Wisdom shift priority at different times in adult life and under different circumstances. Is an increase in wisdom necessary to an increase in care? In a given situation, is there a difference in priority of virtues between individuals belonging to different age or subculture groups?

Gilligan (1982), who studied under Kohlberg, published findings from several studies focused on determining the developmental phases of moral reasoning in women. Women's moral development was found to be centered on the knowledge of the importance of intimacy, relationships, and caring that is considered intuitive and instinctive by men and not valued by them until midlife. Gilligan (1982) described

> The outline of a moral conception different from that described by Freud, Piaget, or Kohlberg . . . [where] the moral problem arises from conflicting responsibilities rather than from competing rights and requires for resolution a mode of thinking that is contextual and

> narrative rather than formal and abstract. (p. 19)

Three issues critical to the psychological development of women were listed as: determining worth of self in relation to others, claiming the power (right) to make choices, and accepting the responsibility for choice.

From a study of women seeking counseling for decision making about having a legal abortion, Gilligan (1982) elicited three stages or phases of reasoning among the women. The first phase was "focused on caring for the self in order to ensure survival" (p. 74) consistent with feeling powerless, disconnected, and alone. Women may choose isolation to protect themselves from hurt. Morality is related to obeying sanctions imposed by society.

A transitional phase where such decisions are retrospectively called selfish leads to a second phase where "the good is equated with caring for others (Gilligan, 1982, p. 74). Successful passage through the transition requires the "enhancement of self worth" to include "the possibility for doing the 'right thing,' the ability to see in oneself the potential for being good and therefore worthy of social inclusion" (p. 78).

In the second phase, "moral judgment relies on shared norms and expectations . . . [with] consensual

judgment about goodness as the overriding concern as survival is not seen to depend on acceptance by others" (Gilligan, 1982, p. 79). The traditional feminine attributes of caring for others, the self-sacrificing model, are valued to the exclusion of self-expression and consideration. Conflict occurs around the issue of hurting, or if hurting is unavoidable, how to choose between evils or select a victim. This stage is compared to Kohlberg's third stage of moral development in that "the woman becomes suspended in a paralysis of initiative with respect to both action and thought" (p. 82).

The transition to the third phase begins with a reconsideration of the relationship of self to others and a shift in concern from being "good" to being "responsible." In the third phase the woman "strives to encompass the needs of both self and others, to be responsible to others and thus to be 'good' but also to be responsible to herself and thus to be 'honest' and 'real'" (Gilligan, 1982, p. 85). Successful negotiation of the transition depends on the adequacy of the self-concept, the determination that the woman can and should assume responsibility for choices, and that responsible decisions must include considerations of personal wants and needs.

Women differ from the predominantly male subjects studied by Kohlberg. Gilligan (1982) described the difference in:

> Reconstructing hypothetical dilemmas by gaining or supplying more information about the nature of the people and places involved which leads to recasting the moral judgment from a consideration of the good to a choice between evils. The moral action is that which does the least harm to self and others. (p. 101)

Kohlberg, on the jacket cover, called the work "an important and original contribution to the understanding of human moral development in both men and women . . . [having] important implications for philosophical as well as psychological theory."

The study of ethics particular to the nursing profession has been principally under the umbrella of medical ethics which Veatch (1976) stated cannot be done in the abstract since "it is real-life, flesh-and-blood cases which raise the fundamental questions" (p. 11). The questions cited by Veatch as significant for consideration included: what makes right acts right; to whom is moral duty owed; what kinds of acts are right; how do rules apply to specific situations; and what ought to be done in specific cases (pp. 2-14). Particular to nursing another question needs to be added--who ought to decide in a specific case.

Nursing literature related to ethics is of two types--philosophical examinations of theories or issues requiring decisions in nursing practice and research on measurement of decision making stages. Davis and Aroskar (1978) presented an overview of ethical theory and its application to general issues recurrent in nursing practice. Shelly (1980) iterated the necessity of a Christian philosophy in applying ethical theory to nursing practice, complete with scripture references for study of the ethical dilemmas discussed. Curtin (1979) called nursing "a moral art" which included "the wise and human application of our [nurses'] knowledge and skill" in discussing a philosophical concept of the nurse as advocate (p. 2). The findings of Gilligan (1982), being recently published, have not been discussed or included in research in the nursing literature.

Nursing ethicists, Levine (1977), Sigman (1979), Aroskar (1974), and Carper (1979), advocated emphasis on autonomous professional nurses being actively involved in moral decision making. This differs sharply from the principles advocated by Aikens for nursing students in 1924 which included:

1. Meekly accept, as right and necessary, much that she cannot understand.

2. Try to see every situation from the viewpoint of those in authority.

3. Analyze her own motives and be sure that they are pure and unselfish (Shelly, 1980, p. 26).

Studies related to measurement of stages of moral reasoning in nurses were reported by Murphy (1976), Crisham (1981), and Ketefian (1981a, 1981b). Murphy (cited in Ketefian, 1981a) studied 120 nurses and found that only 5% used Stage 5 as the modal stage and that there was no difference between supervisory levels of areas of practice.

Chrisham (1981) developed a tool to measure nurses' responses to recurrent moral dilemmas in nursing practice. The tool, the Nursing Dilemma Test (NDT), was correlated with the Defining Issues Test (DIT) developed by Rest. Comparisons by level of nursing and years of nursing practice with measurements of knowledge of moral principles, familiarity with the nursing dilemmas, and practical considerations in making judgments were included. The validity and correlations reported are questionable due to the use of repeated *t* tests for post hoc determinations of significance. An interesting finding of important considerations stated by the respondents in responding to the dilemmas was presented. The

respondents enumerated the following "distractions and pressures in the hospital setting":

> Hospital policy which conflicted with their own concepts of fairness; time constraints for a broad range of services; opposing loyalties to the nursing profession, the hospital, and the patient; confusion about the most effective way to utilize the vast and expanding body of professional knowledge; lack of clarity about their own responsibilities and authority; contrary expectations from patients, administrators, and peers. (Chrisham, 1981, p. 110)

Ketefian (1981a) found a significant relationship between critical thinking, measured by the Watson and Glaser Critical Thinking Appraisal Test Form ZM, and the level of moral reasoning measured by the Defining Issues Test of Rest. A significant difference was reported on the level of moral reasoning between nurses with technical and professional education. These findings supported the premise of Kohlberg that intellectual development must precede moral reasoning development. In a later study, Ketefian (1981b) developed the tool to measure nurses' judgments about nursing dilemmas (JAND) which is discussed in detail in Chapter 3.

Summary

The popular, philosophical, and research literature related to the problem and conceptual framework of the study has been reviewed in this Chapter. The

developmental processes through adulthood have been presented, including moral development as a special case. The related concern of sexism as a cultural factor in the development of female nurses has been explored.

From this review, factors which seem important to consider in collecting and analyzing the data for the study have been extracted. These factors will be further enumerated in the methods for collection and treatment of the data presented in Chapter 3.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

The study was a descriptive exploratory survey designed to describe the decision-making patterns of female nurses at adult life crisis points and in situations involving moral conflict and patterns of personal characteristics associated with the decision making. The study was classified as survey research, a form of field study, by Kerlinger (1973). "The personal interview far overshadows the others as perhaps the most powerful and useful tool of social scientific survey research" since one can ascertain the respondent's own reasoning, reasons, and beliefs in personal interviews (Kerlinger, 1973, p. 412). Field studies were described as "strong in realism, significance, strength of variables, theory orientation, and heuristic quality" by Kerlinger (1973, p. 406).

A phenomenological approach was utilized in this study. Ihde (1979) described first level phenomenological investigation as following three rules "(a) attend to phenomena as and how they show themselves, (b) describe

(don't explain phenomena) and (c) horizontalize or equalize all phenomena initially" (p. 38). In the discussion, the necessity of suspending judgment about the essential or hierarchical elements of phenomena was emphasized. Following these steps, the researcher is instructed to "seek out structural or invariant features of the phenomena" (Ihde, 1979, p. 39) which implies determining repeated patterns after sufficient examples are collected.

These rules guided the collection and analysis of data to describe the patterns of decision making through analysis of reports of personal, professional, and moral conflict situations. The patterns of personal characteristics were determined and sexist attitudes measured for comparison with the patterns of decision making.

Setting

The study was conducted in a large city in the southwestern United States. The data were collected by the researcher in the private residences of the subjects. The residences were selected to provide a subjective feeling of ease for the subjects and to allay any concern about revealing professional and personal information in the work setting.

Population and Sample

The target population was female registered nurses. To increase the homogeneity of the sample, employees of one hospital were utilized who fulfilled a number of other criteria.

The hospital, having approximately 500 beds, is affiliated with a protestant religious organization and has non-profit status. A full range of medical services is offered including hemodialysis and cardiovascular and neuro surgery.

A listing of 481 American-born nurses was obtained and the 205 who met the criteria were extracted. Full-time employment for at least one year was required to assure experience and similarity of roles, functions, and exposure to the institutional philosophy. An age range of 25 to 34 years was selected to focus on the Catch-30 adult life crisis point (Sheehy, 1974). Potential subjects who did not meet the criteria were deleted for the following reasons: newly hired, 19 or 7%; men, 16 or 6%; new graduates, 34 or 13%; part timer, 87 or 31%; over age 34 years, 83 or 30%; and both overage and part time, 37 or 14%. Once the alphabetical listing of 205 potential subjects was numbered, the Radio Shack TRS-80™ with RND

(Random Numbers Determination) program was used to generate a series of random numbers for obtaining the sample.

Protection of Human Subjects

Since audio-tapes of personal interviews were to be used, permission was obtained from the Human Subjects Review Committee of The Texas Woman's University at Parkland Campus. The Director of Nursing of the target hospital granted permission to study the registered nurse employees, but requested that the institution not be identified in the report. The listing of potential subjects was obtained in the Nursing Service offices.

Individual potential subjects were contacted before or after working hours either at the hospital or at home. The Oral Presentation (Appendix A) was made. The subjects were informed of the problem, purposes, and potential benefits of the study. Subjects were assured that they had been randomly selected after approval of the nursing director and that there was no obligation to participate or to remain in the study. The potential risks and actions to protect confidentiality were explained. When verbal agreement was obtained, appointments were scheduled. Written consent (Appendix B) was obtained prior to any audio-taping. The audio tapes are to be erased after completion of the written report.

Instruments

Three instruments were utilized for data collection, including an Interview Guide developed by the researcher for this study (Appendix C), the Sexist Attitudes Toward Women Scale (Appendix D) developed by Benson and Vincent (1980), and the Judgments about Nursing Decisions (Appendix E) reported by Ketefian (1981b).

Interview Guide

The Interview Guide was developed to organize questioning to determine the individual descriptions of the background context of decisions made; the decisions made during past adult life crises; and the considerations in decision making related to the perception of self, personal safety, time, and fruitfulness of the subjects. The items relate to place of birth, ethnicity, family of origin, selection of nursing as a career, selection of jobs and changes of jobs, work experience, considerations on decisions, the perception of the reasoning behind decisions, and personal and professional expectations in the future.

The questions were stated informally and arranged for continuity in questioning. Since the Guide was a tool to order discussion mainly, reliability and validity studies were not conducted. The Guide was tested with

one subject from the target hospital who met all criteria except full-time employment and was found to be sufficient for obtaining the desired data.

Sexist Attitudes Towards Women Scale

The Sexist Attitudes Towards Women Scale (SATWS) was developed to measure seven components of sexism (Benson & Vincent, 1980). The components were collapsed to the six listed below after initial analysis.

> 1. Attitudes that women are genetically inferior (biologically, emotionally, intellectually) to men.
>
> 2. Belief for the premise that men are entitled to greater power, prestige, and social advantage.
>
> 3. Hostility toward women who engage in traditionally masculine roles and behaviors or who fail to fulfill traditional female roles.
>
> 4. Lack of support and empathy for women's liberation movements and the issues invovled in such movements.
>
> 5. Utilization of derogatory labels and restrictive stereotypes in describing women.
>
> 6. Evaluation of women on the basis of physical attractiveness information and willingness to treat women as sexual objects. (Benson & Vincent, 1980, p. 278)

The scale was tested using a 141 item pool on a sample of 886 persons (487 women and 399 men) including 484 college students. The response options were scaled on a 7-point Likert-type continuum. Fifty items were

deleted as non-discriminating after initial analysis. Intercorrelations were determined using 10 items on each of the six components. These were then collapsed by taking the highest intercorrelations to the 40 items in the published scale. Of these items 24 are sexist statements and the remaining 16 are non-sexist (Benson & Vincent, 1980).

The reported coefficient alpha for internal consistency reliability yielded values greated that .90. Construct validity was concluded since the SATWS correlates with other measures of sexism; correlates with instruments measuring similar constructs; correlates "in expected ways with attitudinal and behavioral self-report measures in other domains"; and is uncorrelated with concepts different from sexism (Benson & Vincent, 1980, p. 286).

Judgments About Nursing Decisions

Permission was obtained to utilize the Judgments About Nursing Decisions (JAND) instrument which measures "two components of moral behavior: knowledge and valuation of ideal moral behavior and perception of realistic moral behavior" (Ketefian, 1981b, p. 171). Ketefian surmised that "it is logical to postulate that the degree of a person's moral development will affect the degree to

which a person's nursing actions are ethical" (p. 173). Moral behavior was differentiated as action while moral reasoning was the cognitive developmental process.

The JAND contains 6 stories depicting common nursing ethical dilemmas with 6 or 7 choices of actions as response alternatives. Responses in Column A reflect the knowledge and valuation component, while Column B is the perception of realistic moral behavior component. Two scores can be determined from the instrument.

Coefficient alpha for internal consistency was reported as .70. Validity was based on ratings of "nationally recognized authorities in nursing ethics" following collection and analysis of 100 stories and compilation into the 7 stories in the original instrument (Ketefian, 1981b, p. 173). In a personal communication, Ketefian (1982) stated that only Column B scores are considered reliable.

Correlations of the JAND with the Defining Issues Test (DIT) developed by Rest were reported as .28, significant at the .01 level on knowledge and valuation (8% of variance in column A scores predicted by principled thinking) and as .19, significant at the .05 level on the perception of realistic behavior column (Ketefian, 1981b).

Data Collection

Following oral consent to participate and scheduling an appointment time, the researcher went to the residences of the subjects at the appointed time. Any questions about the research were answered and written permission was obtained prior to tape recording the questioning.

The Interview Guide was used to direct the discussion with an occasional clarifying question used when necessary. The interviews ranged from 1 to 1-1/2 hours.

The JAND was presented as situations where nurses commonly have to make difficult decisions in nursing practice. The subjects read and scored the six stories according to the directions. After each story the subject was asked to discuss her personal experience in similar situations. The personal experiences were described as to subject's position, others involved, the decision options perceived, the decision process, and the action selected. Questions about important considerations were raised. The alternative actions on the stories were discussed as to feasibility and justifiability.

After completion of the JAND, the SATWS was administered. When this was completed, the subjects were

thanked for their participation and reminded that results would be available, if desired, from the researcher who promised to mail the abstract of the study when completed.

Treatment of Data

Wittgenstein (1958) described the process of defining a concept as similar to determining "family resemblances" (p. 32). He cited comparing board games with ball games and other types like card games or noughts and crosses to determine what is common in the uses of the word game. Analysis of the interview data, looking for commonalities of pattern, was approached in this manner. Sexist attitudes and the stage of moral reasoning were treated according to the instructions accompanying the instruments.

Patterns of Decision Making

The elements of patterns of decision making were related to the autonomy of the decision, the personal risk or benefit consideration, and the retrospective evaluation of actions.

Autonomy of decision making was classified according to the following criteria:

1. Forced, where circumstances necessitated one

action over others, i.e., not enough money or personal resources to pursue an option.

2. Passive, where an action was taken at someone's suggestion without serious consideration.

3. Compromising, where action was decided through negotiated agreement with some significant other.

4. Consultative, where a tentative decision was validated with some authority or awareness of an additional option was considered after consultation.

5. Autonomous, where action was selected independently without or disregarding consultation.

The degree of personal risk or benefit involved in decision making was categorized according to the perception of probably gain or loss in sense of self to personal safety. Sense of self included self-concept and professional role concept.

Retrospective evaluation of decisions made was on the basis of the relative satisfaction with past decisions and whether other actions might be taken if the situation occurred presently.

Sexist Attitudes

Scoring for the SATWS, using the 7-point Likert-type scale, involves determining a total score after reversal of the 16 non-sexist statements (denoted with an asterisk

on Appendix D). Total scores range from 40 to 280, the lower the score the more sexist the attitude. Total, mean, and standard deviation statistics were computed for description of the subjects.

Moral Reasoning

Scoring of the JAND involves marking the items for each story as correct or appropriate for the situation or incorrect. The scoring guide is included in Appendix E and yields a maximum score of 37 on both Column A and Column B. Two scores were computed and the percent correct determined.

The level of moral reasoning was determined by comparing the subjective response of the subjects concerning the considerations in deciding the correct items on instrument and of past experiences to the content and social perspective descriptions of the stages of moral judgment listed by Kohlberg (1981, p. 409ff).

Association Among the Variables

Determination of association among the variables was a phenomenological analysis. The classified data were examined for commonalities among the subject and these commonalities were described. No statistical analysis beyond the description of the subjects was indicated.

The commonalities served as the basis for hypotheses for future study of associations or relationship among the variables.

In this Chapter, the methodology, sampling, instrumentation, and data analysis procedure have been presented. In Chapter 4 the findings of the study are presented.

CHAPTER 4

ANALYSIS OF DATA

With the nature of the interview data and phenomenological approach, a detailed description of each of the five subjects in the sample will be presented. The background and personal characteristics are then summarized. The personal and professional decision patterns at the three predictable life crisis points are presented along with the scores on the SATWS and JAND In the Findings section the patterns, sexist attitude scores, and the stages of moral reasoning are discussed and the analysis for associations among the variables is presented. All findings are briefly iterated.

Description of the Sample

All five of the subjects were female, American-born, registered nurses employed full-time for at least 1 year at the target hospital. Three were born in Texas, two in upstate New York. Ages ranged from 30 to 34 years. One was single, one divorced, and three were married.

Subject 1

Subject 1 (S1) was born in a small farming community in upstate New York, but the family moved to a large city soon after. She was the second of six children with one older sister and four younger brothers. Her mother who had a college degree did not work until S1 was about 13 years old. Her father, who wanted to have a dairy farm but had to do other work, changed from construction to long-haul truck driving to earn a living. S1 described a comfortable, happy childhood with her mom "always there, which was nice."

S1 related that she had always wanted to be a nurse but does not know any reasons why and that she did not know anyone who was a nurse who influenced her. When she graduated from high school, her boyfriend, then husband, was going away to college and she chose a nursing school in the same town. They decided to get married before she entered nursing school. The nursing school she selected was a diploma program with "3 years of courses crammed into 2-1/2 years." The teachers were strict and demanding. S1 found the program really tough. She felt well prepared from the education and practice during school.

Her first job, at the age of 22, was selected "because the hospital had the best reputation in the

area," others in the area were not hiring nurses at the time, and the area was close to her husband's home. Her husband had moved back home earlier to manage a large dairy farm when his father became terminally ill with cancer. On the first job, S1 was assigned to a neurosurgical unit although she had requested intensive care. She relates that she learned a lot about nursing and neurosurgical patients. In retrospect she evaluated the unit as well staffed and managed and stated that she made a lot of friends there. She remained on the job for 2-1/2 years. The decision to leave was related to "wanting to move South because we hated the winters." Her father-in-law had died and the dairy farm was sold so she and her husband decided to move. They chose Florida. The hospital S1 selected had a neurosurgical intensive care unit (NICU) which was where she wanted to work. She found the job "very, very frustrating." There were typically two staff for six to eight patients. She often thought of quitting but knew the situation was no better in any of the other hospitals in the area and "the patients would be even worse off if I quit." She considered working for a temporary pool where "they pick their own shifts and make more money," but opted to stay where she knew the routine and what to expect. She

related that she has a need to be familiar with expectations and people to feel competent at work. They remained in Florida for 2-1/2 years.

Two years ago after visiting her family who had moved to East Texas, S1 and her husband decided to move to Dallas. She investigated four hospitals. Two were deleted because of the area of town. A third was considered more desirable because of salary and benefits, but had no NICU. The study hospital was chosen when she was notified the day after her interview of a vacancy in the unit on the shift she wanted.

S1 related enjoying her work and the people she works with--"we get along well together." She has no plans to change jobs at the present. She and her husband recently purchased their first home and are renovating it themselves. They are able to balance personal and professional lives because "we both work strange times" and have arranged mutual split weekend schedules to be together. They have "no set woman's work and man's work chores," and both share care of the household.

She has considered giving up nursing as a career, to be a librarian, during the periods when short staffing and high patient workload have been protracted, but she stated, "I can't imagine myself being anything but a

nurse." S1 cited the most frustrating part of nursing as the view of administrators that nurses are not career people, but just doing a job. This view leads to giving benefits grudgingly and to "little things that are not fair." She has considered returning to school for a B.S.N. but has not decided when to return. At age 31 she anticipates finishing within 5 years, but has not really thought about 10 years from now except that she does not want managerial or teaching positions.

S1 cited the major problem with the nursing profession as the view of doctors, administrators, and the public that nurses do not make decisions about patient care and needs and that nurses are more like servants. These views cause problems in relationships and necessitate the nurses' having to make suggestions and make the doctors think it is their idea. She stated that doctors should work as nurses for a few days to get a better understanding of what all the nurse does.

Subject 2

Subject 2 (S2) was born in Dallas and has lived in the area all her life. She was the second of three children. Her parents were married young, and her mother finished the 10th grade. Mother did not work outside the home until her parents divorced when S2 was 14 years

old. Her mother worked as a waitress since she had no other marketable skills. Her father was a union electrician.

Although she wanted to go to college, there was not enough money, so S2 took a job in a large electronics firm working on an assembly line. She decided to settle down, have a family, and return to school when the children were older. She followed that pattern. She worked at the job for about 5 years until her first child was born at age 23.

S2 was a full-time wife and mother for about 6 years when at age 28 she decided that "there has to be more to life than this" and that nursing school was what she wanted. She related having always wanted to be a nurse. She selected an associate degree program about 40 miles north of her home because it was in a small town, she did not want to drive to downtown Dallas, and she did not want to take the time to go to a 4-year college program. Her husband agreed with her choices. She met and arranged to commute with two other women for the 2 years of school.

During the schooling her family had "a lot of adjusting to do" but was supportive of her venture. She had to learn to "let the boys do without some

supervision" and to accept the house not being so neat. Her husband started helping out by "doing the dishwasher," which she hated doing.

S2 selected the target hospital upon graduation because it was closest to home of the large hospitals and for straight shifts available for nurses. She was recently promoted to Head Nurse on a surgical unit. S2 described herself as aggressive and as wanting to make changes in her unit to improve communication between shifts. She expressed satisfaction with her choice and plans to continue to take courses in business and administration to earn a bachelor's degree in a few years.

She has not considered giving up nursing or leaving her present position. S2 feels supported by her supervisor and nursing administration. She has learned to balance her personal and professional lives by expecting less of herself as a housekeeper and by recruiting her husband's assistance. The family has outings on her alternate weekends off, and her husband attends sports and other events with their two sons when she has to work. S2 describes herself as different from her mother since she has made a career for herself which she enjoys and that she does many things for herself that she wants done. The major problem with the nursing profession

cited by S2 was communicating with others what nurses can do to help patients.

Subject 3

Subject 3 (S3) was the fourth girl and had one younger brother. Mother stayed at home until the brother started school when S3 was 12 and required hospitalization for a "back problem." The family was comfortable in a city in upstate New York. Upon graduation from high school, S3 attended 2 years of college "without much direction" since her parents agreed to support her. At age 21 she moved to California--"it was when the hippies were going to Berkeley"-- and stayed with an acquaintance. Unable to support herself otherwise, S3 attended a 3-months Nurse Aide training course. She returned home when she was unable to get a job. She worked as an aide for about 3 years before going to nursing school. Her parents wanted her to get a degree and she wanted to make more money.

The ADN program was selected since it was close to home and took less time than university programs. It took over 3 years because of a semester's withdrawal because "I was tired of going to school and working full-time" and a long convalescence after back surgery. She

was changed from aide to ward secretary after the surgery.

S3 related being influenced by two instructors, both perfectionists in nursing care. She admits to agreeing that "if you're not going to do it right, don't do it." After graduating, at age 26, S3 could not find a job in her hometown, so she came to Dallas where she could live with her sister. She rejected the job she had planned to take since "they gave me a lot of hassle about my back," and she did not like the "way the hospital looked or the location." Another hospital was rejected since "they wanted me to go to work the next day, and I figured they must be desperate for help" which she equated with having to work too hard. The study hospital was selected because of the location, appearance, and the interviewer who was "nice and kind of laid back." S3 stated that "the people you work with are about 50% of how happy you are in a job." She remained on the job for about 9 months and resigned because of the hours and because she was getting married. She said that "getting married after only 5 months was "probably too fast, but once it's done, it's done."

S3 had two short tenures with medicine-related companies but did not like the work and one part-time,

housewife's shift, hospital job before returning to the study hospital. She has been on the job 4 years and presently works as a staff nurse on a surgical specialty floor. She enjoys the people she works with and the "pace is not too hectic." She expressed feeling too much stress when working with the "sick people" when on a medical floor.

S3 is 4-1/2 months pregnant and anticipates working until close to delivery and after 6 weeks maternity leave. She relates that her husband was not ready to have children because of finances, "but--it happened, so . . . ." She expressed concern that being 32 was nearly too late to start a family.

She has not really considered leaving nursing or what she might prefer to do in the future. She would prefer to work 4 days a week if there were enough money, but her husband is unhappy in his job and is seeking another. The major problem with nursing was cited as having too much to do and not enough authority to get things done.

Subject 4

Subject 4 (S4) was born the first of three children in a large town in west Texas. She recalls a comfortable, happy childhood with her mother at home until S4

was 13 when her mother started substitute teaching. S4 "always wanted to be a nurse," but has no idea how it was decided. She sought the advice of her minister whose daughter was investigating nursing schools and chose an all girl's school in north Texas because it was recommended as one of the top three schools and because she had relatives in the town. Her parents were pleased with her choice of nursing but not with the all girl's school. In retrospect she would not attend a girl's school since "you need other skills from college besides academics."

S4 remembers being in "an awful class" in school because of changes in curriculum and only liking two clinical rotations where the instructors were "clinical specialists teaching in their area who really knew what they were doing." She has worked mainly in obstetrics and pediatrics since. Her first job was in Labor and Delivery in the city-county hospital because "I had to for 6 months, since they let me work there as a student." She left because she felt she was being compromised by the patient load with low staffing. She cited the final straw as being reprimanded for not completing charting according to audit criteria on a night when there were three nurses and a float LVN for 21 patients

in labor and not getting any recognition for the quality of patient care given.

She chose a private hospital for her second job because of a position in pediatrics. S4 rejected the children's hospital nearby because of her experience there as a student where "the nurses didn't seem happy there." During a 4-1/2 years tenure there, the patient population changed to more geriatric and S4 requested a transfer to obstetrics. After some "personnel run-around," she resigned to work at the study hospital.

She decided on the present position 4 years ago because "it was the one place with a position open in Labor and Delivery" and that she "leaned toward it" having heard good things about nursing there. She works the 11-7 shift because of having more control of the environment and "it's a quiet busy."

S4 is the charge nurse and has responsibility for other nurses. She cited a recent situation where she had to counsel another nurse formally as making her examine herself and her practice since she thought "who am I to tell her all these things about her care and relationships when I'm not perfect." She described the head nurse as very supportive in the counseling and stated that she "would not have done it on my own."

Leaving the nursing profession never occurred to S4, but she has considered midwifery or other non-hospital nursing. She has taken some courses, Spanish and literature, but not toward a graduate degree. She has no definite plans for the future, except "not administration" since the counseling incident. S4 stated that she feels she "probably won't get married" although she has been close a few times, but is open to the possibility.

Subject 5

Subject 5 (S5) was born the second of four children in a small town in west Texas but moved to a city when she was 1 year old. Her mother worked as a school nurse--"the Bandaid Queen"--and her father had a small trucking company. S5 attended 4 years of college without graduating because she "couldn't decide what to do." She then started a medical assistant program but did not finish because she got married and moved to Oklahoma. She worked in the office in a clinic there since she had no preparation for other work.

She did not discuss the marriage but related being divorced within 2 years. She later stated that she would like to marry again since "I have only good memories of being married." After moving back home, mother suggested that S5 go to nursing school and she "thought that was

okay. Maybe it took the jolt of the divorce to get me to move."

S5 attended a diploma program "because it was in town and I didn't want to move." She did not investigate other schools. She enjoyed the clinical areas, especially ICU and surgery, where she liked the personality of her instructors.

At graduation she decided to move to Dallas and took the advice of a friend's friend to apply at the study hospital. S5 described arriving at night and "liking the looks of it with all the windows" and liking the interviewer who was nice to her. She took a position without investigating others since she "figured the salary and things were competitive" and she liked the part of town, so she decided "it'll do."

After 8 months on a medical floor, "helping little old ladies to the bathroom," she was transferred to the emergency room. S5 enjoys the job but "gets frustrated with problems and not being able to get to days." S5 related that she would like to move to Assistant Head Nurse or Head Nurse, but that she does "not know how they decide who gets it." She has considered going back to school for a degree and has requested information from a college, but "it didn't come and I haven't pursued it."

She sees herself as different from her mother who is "always busy either sewing or knitting" and from her sisters who do not work but stay with their children. S5 describes herself as "happy just plodding along" and not wanting "anything like school interfering with me doing what I want to do." She said that she was "not very innovative unless someone mentions something" and that she does not "have any big direction in my life."

Sample Characteristics

The background information and personal characteristics of interest are summarized and presented in Table 4.1. Subjects 1 and 4 entered nursing school right after high school and both had always planned to be nurses. Subject 2 wanted to go to school but had to defer due to finances. Subjects 3 and 5 went later in life due to parental suggestions after trying other jobs or careers.

Findings

The research questions for this study related to the patterns of decisions exhibited by female registered nurses and associations of these patterns to sexist attitude scores and stages of moral reasoning. Each of the variables will be discussed in this section.

Table 4.1

Background Information and Personal Characteristics of Subjects

	Subject Number				
	1	2	3	4	5
Age	31	34	32	31	30
Birth Place	New York	Texas	New York	Texas	Texas
Locale	Urban/ Suburban	Urban/ Suburban	Urban	Urban	Urban/ Rural
Family Position	2 of 6	2 of 3	4 of 5	1 of 3	2 of 4
Ethnicity	Not really any	Mixed	None	Jumbled up Texan	
Mother's Education	H.S. Grad.	10th Grade	H.S. Grad.	B.S.	R.N.
Occupation	Housewife/ Teacher (13)*	Housewife/ Waitress (14)*	Housewife/ Librarian (12)*	Housewife/ Sub. Teacher (13)*	School Nurse
Father's Education	H.S. Grad.	H.S. Grad.	College Grad.	B.S.	6th Grade
Occupation	Carpenter/ Truck Driver	Union Electrician	Electrical Engineer	Milling Engineer	Self-employed
Marital Status	Married	Married	Married	Single	Divorced
Age of Entrance to Nursing School	19	28	23	18	25
Nursing Education	Diploma (Pa)	A.D.N. (Tx)	A.D.N. (NY)	B.S.N. (Tx)	Diploma (Tx)
Continued Education	No	Yes, Administration	No	Yes, Spanish, Statistics	No.
Present Position	Neuro ICU Staff Nurse	Gen. Surgery Head Nurse	Opthalmology Staff Nurse	Labor & Delivery Charge Nurse	Emergency Rm. Staff Nurse

*Age of subject when mother went to work.

Patterns of Decision Making

The elements of the patterns of decision making in examining the data were the degree of autonomy and the retrospective evaluation of the decisions. Risk to benefit considerations were infrequent except in discussing the moral questions.

Subject 1. Subject 1 had decided autonomously early in life to pursue a nursing career and chose a school to be near her fiance, later her husband. She is pleased with both decisions. At age 22 she selected a job considering the reputation of the hospital and its location near her husband. After 2-1/2 years, near age 25, she and her husband mutually decided to move to another state where the job was chosen for availability of her clinical specialty. She was not particularly pleased with working conditions but felt there were no better opportunities in the area.

At age 28, the decision was made mutually again to move to another state. The study hospital was selected over a better paying one because of the availability of her specialty and shift preference. She related enjoying her present job especially because she likes her co-workers.

S1 is contemplating a return to school at age 31 but will defer entrance due to renovation expenditures on the house. She does not plan to have children. S1 wants to continue her career but not as a staff nurse forever.

In personal life, she and her husband decide collaboratively what they will do and how to optimize their life together. Professionally, S1 decided autonomously to pursue her chosen specialty but readily admitted that her contentment with job choice depends on relations with her co-workers.

Subject 2. Subject 2 wanted to go to college after high school but had to go to work because of financial problems, a forced choice. She married young and remained on her job until she had children, then was a homemaker accepting her husband's desires passively. At age 28, entering Catch-30, she decided to pursue the nursing career with agreement of her husband. Arrangements were negotiated during the schooling.

She selected her first nursing job for proximity and straight shifts, presumably with her husband's consultation. She was pleased with the decision of nursing, the study hospital, and her recent promotion. She admitted to frequent consultation for validation and support for activities from her supervisor.

In personal life she and her husband compromise and support the arrangement. In professional life she has a consultative pattern, that is, she makes tentative decisions with supervisory consultation. She admitted that the support is necessary to her satisfaction with her decisions.

Subject 3. Following high school graduation, Subject 3 attended 2 years of college at her parents' suggestion. At age 21, Pulling Up Roots, she moved across the country at the invitation of a college acquaintance. She decided to take a nurses aide training course to be employable, but had to return home to find a job. At her parents' suggestion she returned to school for a nursing degree at age 23.

After graduation, with interruptions for surgery and to rest from work and school simultaneously, she moved to find employment to an area where she had relatives. She had four short-term jobs before settling at the study hospital four years ago. S3 related preferring a slower work pace and having patients who are "not too sick." She related liking her job and having no plans to change her position.

S3 stated that she probably was married after too short an acquaintance with her husband and that the

pregnancy "just happened," indicating passive decisions, but expressed no reqret about either event.

The patterns of decisions of S3 have been passive or compromising in both personal and professional lives.

Subject 4. Subject 4 always wanted to be a nurse and decided on a school with consultation from her minister. In retrospect a coeducational school would have been more beneficial. She chose to work during her schooling to gain more experience as a nurse and was obligated to remain in the city-county hospital following graduation. She resigned after the 6 months obligation because she felt compromised as a professional nurse.

Her job selections have been based on availability of positions in the clinical areas she prefers, excepting the children's hospital where she believes the nurses are not happy. S4 likes having some control of the work environment, but not having to exert that control over other nurses. She feels a need for consultation and support from her supervisor when she has to evaluate others' performances.

S4 shows consultative and autonomous patterns of decision making. Consultation is generally employed where other people are the object of the decisions. Personally she is autonomous.

Subject 5. Subject 5 is generally passive in decision making. She entered nursing later in life at the suggestion of her parents and examined only the study hospital at the suggestion of a friend's friend. She requested a transfer from a busy medical area and would have taken almost anything to get away. She described herself as needing suggestions from others and as happy just plodding along. She has not really considered changing jobs although she is often frustrated at conditions at work. At age 31, she has no definite plans for the future although she thinks she would like to progress into nursing management and to get a bachelor's degree sometime.

Patterns. The patterns of personal and professional decisions of the subjects at previous adult life crisis points are presented in Table 4.2. In three of five subjects, the patterns differ between personal and professional patterns suggesting that different language games are in effect.

The three subjects who are married have a compromising pattern in their personal life at present, acting on tentative decisions with consent from their husband or participating in mutual discussions to reach decisions. Subject 3 changed from passive to compromising around

Table 4.2

Personal/Professional Patterns of Decision Making
at Life Crisis Points

Life Crisis Points	Subject Number				
	1	2	3	4	5
Pulling Up Roots (18-22 years)	Compromising/ Autonomous	Compromising/ Forced	Passive/ Passive	Autonomous/ Consultative	Passive/ Passive
Trying 20s (22-28 years)	Compromising/ Autonomous	Compromising/ Passive	Passive/ Passive	Autonomous/ Autonomous	Passive/ Passive
Catch 30 (28-32 years)	Compromising Autonomous	Compromising Consultative	Compromising Compromising	Autonomous Consultative	Passive Passive

Catch-30. Subject 4 has been autonomous in her personal life, remaining single, throughout the stages. Subject 5 who is divorced and describes herself as "happy just plodding along" has been passive throughout the crisis points, relying on suggestions from others to determine her direction.

The professional patterns are a bit more diverse. Subject 1 made job choices and choices of her actions in difficult situations autonomously. Subjects 2 and 4 operate with a consultative pattern--seeking support and assistance from supervisors for their tentative decisions about actions related to patient care activities, interpersonal interactions, and supervision of other nurses. Subject 3 attempts to remain not too involved with patient care and to arrange a position where she does not feel too much strees. She compromises for what she wants. Subject 5 is consistent in being passive in professional as well as personal situations. She passes any problems on to her supervisors and does what the physicians tell her since she believes they are responsible for the consequences.

Sexist Attitudes

On the Sexist Attitudes Toward Women Scale (SATWS), the scores ranged from 212 to 276 with a maximum of 280,

with the higher scores being less sexist. The mean score was 235.2 with a standard deviation of 23.34. Subject 1 scored greater than 1 standard deviation above the mean. Subject 2 at 1 standard deviation below the mean. Subject 3 scored 246; while subject 4 had a score of 222. Lastly, subject 5 achieved a score of 220.

Of the nine items having four different responses among the subjects, two were related to genetic inferiority; three to traditional male-female role separation; one to lack of support for women's liberation; and three to women's physical inferiority. On three items (Nos. 7, 13, and 33) all subjects strongly disagreed about the traditional male-female role separation component related to being in charge, premarital sexual activity, and a woman's place as in the home.

Of the 40 items on the scale, nine items each were related to genetic inferiority and traditional male-female role separation components of sexism. Seven items were related to notions about women's physical attractiveness. This loading of the scale on the three components may have affected the scores in the sample so that the scores are not representative of the degree of sexism. Comparing the scores on the SATWS to the decision

patterns, there is no consistent association among the five subjects.

Judgments About Nursing Decisions

The Judgments About Nursing Decisions (JAND) has a maximum score of 39 on both Column A, ideal moral behavior, and Column B, realistic moral behavior expectations. The scores of the subjects are presented in Table 4.3. The range on Column A was 30 to 37 points with a mean of 33.6. On Column B, scores ranged from 24 to 30, with a mean of 27.2. The difference between Columns A and B ranged from 4 to 9 points.

Subject 1 who was autonomous professionally and ranked least sexist scored highest on Column A with 37 of 39 correct. She had the highest difference score at 9 between the two columns indicating that she expected the average nurse to perform at a lower level than the nurse should.

Subject 5 who was passive in personal and professional decisions and below the mean for sexist attitudes (second most sexist) scored lowest on Columns A and B of the JAND with a difference score of 6 between the two columns.

Table 4.3

Scores and Percentage Correct on JAND with Difference between Columns A and B

	JAND Scores				
Subject	Column A	Percentage Correct	Column B	Percentage Correct	Difference
1	37	95%	28	72%	9
2	33	85%	27	69%	6
3	34	90%	27	69%	7
4	34	90%	30	79%	4
5	30	79%	24	62%	6

Stage of Moral Reasoning

The stage of moral reasoning was determined by examining the responses of the subjects in descriptions of similar personal experiences and the considerations in selecting responses to the scenarios on the JAND. Examination of the six scenarios revealed that five of the scenarios are concerned with the ethical principles of veracity and/or autonomy. Number 5 concerns staffing--too few nurses for too many sick patients--which might be representative of the principle of justice. Representative statements of the subjects are included in the discussion of stage of moral reasoning.

Subject 1 functions at Stage 5, the Stage of Prior Rights and Social Contract or Utility, in the majority of decisions. She frequently reiterated the right of patients to make choices concerning their care and treatment. She cited the nurse's professional responsibility as giving support and information for the patients' decisions. If the patient is deceased, the autopsy scenario, or incapaciated, then the family must decide. "I think it's the wife's decision. No one should try to influence her. She has to live with it."

She described an incident where she had witnessed a physician being rude and verbally abusive to another

nurse in front of a patient and his family. S1 reported the incident to her head nurse and director of nurses who made reports to administration and planned further action against the physician. The nurse in the incident "backed down" and there was no further action. S1 stated "I did all I could do, I followed my channels" and continued "then I was looked on like a troublemaker."

Subject 1 expressed her feeling of obligation to care for patients assigned to her as "best I possibly can." To her co-workers she believes she should maintain a professional and friendly work environment. Although she feels administrators are not always fair, she adheres to policies of the hospital. She readily admitted that a major factor contributing to her job satisfaction is the good relationship she enjoys with her co-workers.

Subject 2 functions at Stage 4, the Stage of Social System and Conscience Maintenance. She expressed concerns for patient safety and support by nurses for patient's decisions. In scenario 1 which concerns reporting a medication error, she stated that "it is unthinkable not to report it if there is any question of the patient being hurt." She related not believing in lying for any reason but said that she might advise a patient to seek a second medical opinion if the patient

was uncertain about having a particular treatment or a particular physician perform the treatment, especially if she did not think the physician was being honest or was capable of performing the treatment.

She related seeking counsel and assistance from the supervisors when she has problems and before "big decisions" and that they "always help out." She does not know and has not considered what she would do if they were not supportive and helpful.

Subject 3 functions principally at Stage 3, the Stage of Mutual Interpersonal Expectations, Relationships, and Conformity, but expressed some lower-stage reasoning in concerns that others might try "getting even" if reported for behavior and for not covering up mistakes because "it might be found out later." Her expectations of nurses were that they be a sounding board, reassure and support patients in their decisions, "shouldn't get the doctor in trouble," and support the patient's right to make decisions.

She felt that patients should expect nurses to "give good nursing care" and not to try to change the patient's values or influence their decisions beyond giving information. Subject 3 stated that she would decline to give her opinion about treatments and physicians because that

is "not the nurse's responsibility." The action of a joint conference on two of the scenarios was "a good idea" but she added "I wouldn't do it myself. I try not to get that involved with patients. Maybe it's for my own defense, but I don't."

Subject 4 functions at Stage 4, the Stage of Social System and Conscience Maintenance. She mentioned frequently the necessity of a trusting relationship between physicians, nurses, and patients, especially in the Labor and Delivery area where she works. She has chosen to work nights since there are not so many family members and others around in the area. She believed she has some control over the environment during that time period. "The doctors are there (in the sleeping rooms) if you need them, but not there like at other times." Also, the Chief of Staff is available to nurses for concerns about medical practice or patient care. She admitted that she might encourage a patient to get a second opinion if concerned about a decision, that she has "written up some incidents" for the Chief of Staff to review, and that she "probably would hedge and not reveal my opinion" about a treatment unless she evaluated the person as "stable, emotionally and mentally" if asked by a patient what she would do about having an operation.

Her decision to counsel another nurse, whom she described as "a personality problem" and "very self-centered and you can't be self-centered and be a nurse," was "pushed on me by the head nurse . . . to have something on paper" in the event of future problems with the nurse. Subject 4 recounted having informal counseling sessions with other nurses who responded or they were given minimal merit increases. She gave the impression that she would not accept an administrative position because she did not want the responsibility for directing other nurses' behavior.

Subject 5 functions principally at Stage 3, the Stage of Mutual Interpersonal Expectations, Relationships, and Conformity. She feels that people should be honest and that patients or family members should not be "pushed against their wishes" in deciding about treatments. She expressed frustration with the situation where operative consent forms for minor surgery "are not all filled out" before she goes to obtain a signature and refers parient's questions to their physician or her supervisor for answers.

Subject 5 admitted that she has administered some drugs when she "mentally just questioned" the dosage and that "I'm glad the doctor is there to manage any

complications." Concerns about quality of care, staffing, and some other problems she has discussed with other nurses "but not any further." She felt that any problems should be brought to the head nurse or supervisor and they should take care of it. If she were the supervisor, she guessed, "I'd have to learn what to do to take care of things."

As was expected, four of the five subjects function at the Conventional Level (Stages 3 and 4) of Moral Reasoning. Only Subject 1 functions at the Post Conventional Level. Of interest however, was the consistent mention of the context of the situation and of the action options. Frequently expressed concerns were related to:

--being sole support of a family might influence the options one could reasonably consider,

--maintaining supportive relationships with co-workers;

--the nurse's position within the hospital structure,

--and maintaining personal and professional autonomy within the constraints of various nursing positions.

Summary of Findings

The problem of the study and the research questions concerned whether there are consistent patterns of deci-

sion making in female registered nurses in personal, professional, and moral conflict situations and whether these patterns were associated with certain personal characteristics. The summary of the data on present decision patterns, sexist attitudes, and stage of moral reasoning is presented in Table 4.4. The data shows no consistent associations among the variables.

The patterns of decisions differ between personal and professional decision making for all but one subject. Subject 1 is autonomous in professional decisions, least sexist, highest on the JAND and stage of moral reasoning. Subject 5 is passive in professional decisions, second most sexist, lowest on the JAND, and lower on stage of moral reasoning. The other three subjects are between these extremes and show no consistent pattern.

The personal characteristics (shown in Table 4.1) show no consistent association with the variables of the study. The married state is associated with a compromising personal decision pattern during or following Catch-30. Family position, family background, nursing education, or nursing experience are not associated with decision pattern, sexism, or stage or moral reasoning.

Table 4.4

Summary of Subject Data by Variable

Variable	Subject Number 1	2	3	4	5
Present Decision Pattern (Personal / Professional)	Compromising / Autonomous	Compromising / Consultative	Compromising / Compromising	Autonomous / Consultative	Passive / Passive
Sexism (SATWS Score) X = 235.2 = 23.34	276 (+ISD)	212 (-ISD)	246	222	220
JAND Scores (A/B)	37/28	33/27	34/27	34/30	30/24
Stage of Moral Reasoning	5	4	3	4	3

An incidental finding was that all subjects related contextual features of the scenarios on the JAND as effecting their responses on Column B, the realistic moral behavior component. Even when the subjects knew what a nurse should do, situational context and factors would likely affect what the practicing nurse would likely do.

In Chapter 5, the Summary of the Study, the problem, methods, findings, conclusions, and recommendations for further study are discussed.

CHAPTER 5

SUMMARY OF THE STUDY

This chapter contains the summary of the study and a discussion of the findings. The conclusions drawn from the findings are presented. Recommendations for further study are included.

Summary

The problem was to determine whether patterns of decision making were definable and consistent in personal, professional, and moral conflict situations across adult life crisis points in female registered nurses. The research questions asked about specific associations among the variables and whether any personal characteristics including sexist attitudes were associated with the patterns of decision making. The conceptual framework for this study included Lebensformen or forms of life from Wittgenstein (1969, 1974) with associated language games, moral reasoning theory of Kohlberg (1981) as a special case of the Lebensform being certain, and the adult developmental crisis concept of Sheehy (1974) as a parallel to moral development.

To determine patterns of decisions, it was necessary to obtain descriptions of past decisions. This was accomplished through personal interviews of the subjects via the prepared Interview Guide. During the interview, the data about personal characteristics were obtained. Sexist attitudes, related to inferiority of women to men, were measured using the Sexist Attitudes Toward Women Scale (Benson & Vincent, 1980).

The Judgments about Nursing Decisions instrument (Ketefian, 1981b) was administered to measure knowledge of ideal moral behavior and the expectation of realistic moral behavior. Descriptions of previous similar experiences and of considerations in selecting actions was utilized in determining the stage of moral reasoning.

When the data collection was completed, the interview recording and the two instruments were analyzed. Each subject was described by personal characteristics, decision patterns at early adult life crisis points, and scores on the instruments. These descriptions were compared for patterns and associations among the variables to answer the research questions.

Discussion of Findings

Patterns of personal and professional decision making were determined. In some subjects there was a change

in pattern in either personal or professional decision making at the early adult life crisis points, but not consistently. The sexist attitude scores differed from the mean only in the most autonomous, least sexist and the least autonomous, most sexist subjects. There were no consistent associations between sexist attitudes and decision pattern.

On the moral conflict scenarios there was a consistent difference between the knowledge component and the expected behavior of the nurse. Nurses were not expected to act in the ways they <u>should</u> in the opinion of the subjects. In the discussion of the JAND conflict situations, the subjects expressed concerns for the consequences of some actions. Examples of the concerns were that the nurse might lose her job, might be considered going beyond her responsibility or authority, and/or might interfere with relationships between herself and others or between the physician and the patient. Concerns about lying and protecting the patient's right of decision making were frequently expressed.

The findings of this study that the female nurse subjects perceived differences about what a nurse <u>ought</u> to do according to the Kohlberg stages and what a nurse <u>would likely</u> do can be understood as reflecting the

difference in developmental process between women and men described by Gilligan (1982) rather than a moral retardation according to the Kohlberg theory. Examination of the professional decisions from Gilligan's (1982) description of women's moral developmental phases explains the findings. Moral reasoning in personal decisions was not investigated in this study as a separate form of life from the professional decisions measured by the moral conflict scenarios of the JAND.

Subjects 3 and 5 who are respectively compromising and passive in professional decision making remain in the first phase. Subject 5 does not want school or other interferences with what she wants to do. To survive, she "just plods along," does not take chances of getting hurt, and follows orders and rules even when she mentally may question them because she sees others as responsible for taking actions. Subject 3 thinks that a nurse ought to do her best, but tries not to get "too involved" with patients. She cited her marriage and subsequent pregnancy as "just happening, so . . ." and stated she would not accept responsibility for some actions on the JAND even though she called them good ideas.

Subjects 2 and 4 who are both consultative in their professional decision making are in phase two. Both

adhere to the principle of veracity, excepting saying anything to devalue the reputation of a physician or interfere with the physician-patient relationship. Both advocate accepting the patient's decisions as the patient's right and caring for others needs and concerns. Subject 4 is perhaps at the transition in evaluating her concept of self to determine whether she can and should be responsible for her actions as exemplified in the counseling where she had to have the support of the head nurse to actually perform the counseling.

Subject 1 seems to have attained the third phase since she recognizes those factors that she needs as well as the reality of situations at work. She has acted on her evaluation of situations and dealt with consequences and adjudged that she did all that she could. She has clarified the relationships of self to husband, co-workers, and others. She was autonomous professionally and least sexist.

Sexist attitudes as measured were not consistently related to the subjects' phase of moral development, but seem to be a part of self-concept. Self-concept is focal in moving through the transition from phase two to phase three where the woman must evaluate herself in relation

to others as capable of being responsible and having the right to act responsibly.

Conclusions and Implications

Considering the congruence of the findings of this study with the description of women's moral development by Gilligan (1982), there seem to be two language games in moral reasoning--one feminine with nonmaleficence as a focus and the other masculine focused on abstract justice. The differences between patterns of decision making in personal and professional situations suggest these are different forms of life. Professionally the nurse may be autonomous where she conserves the patient's right to autonomy and provides support and caring in consideration of the nature of the relationship. Personally, if she is married, she is likely to change her decision pattern for preservation of the marital relationship for mutual support and benefit.

The adult life crisis points of Sheehy (1974) were not found to relate to change in all subjects, but, with no longitudinal data, no conclusions can be drawn from this study. The sexist attitude measure showed no consistent association with decision pattern, but that may have been the result of heavy loading of the tool on

three of the six components of sexism. The extreme scores showed a pattern.

Avoidance of the naturalistic fallacy will require further study to validate the differences and patterns found in this study. Debate within the nursing profession is necessitated to clarify the appropriate moral approach for professional practice. Further study across nursing specialty areas, across adult life crisis points, and with larger samples is indicated.

Recommendations for Further Study

Finding that there is an association between patterns of decision making in the different forms of life of female nurses suggests further study of the factors associated with successful transition through the phases, assuming that professional practice requires phase three moral development. Validation of the forms of life and of parallels among them in development is needed with longitudinal studies and comparison studies among nursing specialties and functional areas. Research to determine the association of personal and professional moral development to the phenomena of "reality shock" and "burn-out" would be important to counseling students and practicing nurses experiencing job dissatisfaction.

Comparison studies to other female-dominated professions to determine the generalizability of the forms of life and developmental phases would be helpful in contributing to the knowledge of development of women and the comparison of strategies for enhancing that development.

APPENDIX A

ORAL INTRODUCTION

My name is Carolyn Bell and I am a nurse pursuing a doctoral degree at Texas Woman's University. I am conducting a research study as a part of the degree requirements. I have permission from Dr. Woodard to conduct the study of nurses at Presbyterian Hospital. You were randomly selected from the listing of full-time female registered nurses for the study if you agree to participate.

The study concerns decision making and the circumstances that affect decisions in nursing practice. The purpose is to have a better understanding of the personal and professional factors that influence nurses' decisions in clinical practice. Hopefully with a better understanding of these factors, strategies can be developed to help nurses be more aware of their decision making and make them more efficient in making decisions.

I would like you to participate in the study. What you would do is to be interviewed about your nursing practice history--like what jobs you've had, why you changed, etc.--and breifly about what influenced you and how you decided. There are two other parts. One is a tool to measure attitudes about women which needs to be filled out. The other is about decisions when there is a

conflict of interests. The interview will probably take a couple of hours.

The interview will be tape recorded so I don't have to take notes and so that the factors of interest can be determined. The tape will not be available to anyone but me and my advisory committee. The tape will be erased when the study is completed to be sure that your responses remain confidential.

If you are willing to participate, I would like to schedule a time when we can meet. I will come to your house for the interview and will have a written permission form for you to sign. If you have any questions about the study, I will be glad to answer them. If you decide that you prefer not to participate, you may withdraw from the study at any time. Whether or not you choose to participate will have no effect on your employment at Presbyterian Hospital.

Are you willing to participate in the study? If "yes," when is it convenient for us to get together.

APPENDIX B

Consent Form
TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

(Form A--Written presentation to subject)

Consent to Act as a Subject for Research and Investigation:

The following information is to be read to or read by the subject. One copy of this form, signed and witnessed, must be given to each subject. A second copy must be retained by the investigator for filing with the Chairman of the Human Subjects Review Committee. A third copy may be made for the investigator's files.

1. I hereby authorize Carolyn M. Webb Bell
(name of person(s) who will perform procedure(s) or investigation(s)

to perform the following procedure(s) or investigation(s): (Describe in detail)

(a) conduct and tape record an interview relating to my past work history and the circumstances at points of change.

(b) administer two printed tools to measure factors related to professional decision making.

2. The procedure or investigation listed in Paragraph 1 has been explained to me by Carolyn M. Webb Bell .

3. (a) I understand that the procedures or investigations described in Paragraph 1 involve the following possible risks or discomforts: (Describe in detail)

(a) my identity might be revealed, but is protected as explained.

(b) I might have some emotional reaction to remembering.

(Form A--continuation)

3. (b) I understand that the procedures and investigations described in Paragraph 1 have the following potential benefits to myself and/or others:

a better understanding of those factors that influence professional decision making in nurses and, perhaps, ways of becoming more efficient in decision making.

(c) I understand that -- no medical service or compensation is provided to subjects by the university as a result of injury from participation in research.

4. An offer to answer all of my questions regarding the study has been made. If alternative procedures are more advantageous to me, they have been explained. I understand that I may terminate my participation in the study at any time.

_____ _____

Subject's Signature Date

APPENDIX C

Interview Guide

1. Where were you born?

2. How would you describe your nationality or ethnicity?

3. Did you grow up in an urban, rural, or other area?

4. What was your position in the family?

5. What did your parents do for a living?

6. How much schooling did your parents have? (omit if answered above)

7. In what ways is your life different from or similar to that of your parents?

8. When did you decide to become a nurse?
   If before 20, Did you reconsider later before school?
   If 28 or after, skip to question 21.

9. What was your reason for the decision?

10. Who do you think influenced your decision? In what manner?

11. What school did you go to for nursing?
    Why that one? How old were you when you went?
    How old when you finished?

12. Who do you think influenced you most while you were in school? In what way?

13. Did you go to work right after school? (If "No", Why not?)

14. What job did you take? Why that one? What else was happening in your life at the time?

15. When did you leave that job? Why did you choose to change? (Note the age and other considerations at the time of any changes in place or position of employment)

16. What was the next job? Why did you select it? (Note if answered above, delete) Was it better, worse, or about the same as the other job?

*Continue 15 and 16 through the work history, noting any

times of unemployment or limited employment and the reasons and ages of these times.

17. Have you ever considered giving up nursing as a career? When? What do you think made you reconsider? Who or what influenced you to stay?

18. What are your aspirations and/or expectations in the next 5 to 10 years? Personally? Professionally?

19. How have you balanced your personal and professional lives over the years you have worked?

20. What, if any, do you see as problems or deterrents to professional nursing practice for yourself? For other nurses?

---

21. When you decided, were you making a career change or preparing for a career? What were the circumstances?

22. Did you plan to go to work after some period of time? For what reason?

23. How did your children and spouse feel about your going to school/work?

24. How has working affected your personal relationships with others? Your feelings about yourself?

* Return to #9 on the Interview Guide.

APPENDIX D

SEXIST ATTITUDES TOWARD WOMEN SCALE (SATWS)

Instructions: Following the statements below, please indicate your degree of agreement by circling the number according to the following Scale.

Strongly Agree	Moderately Agree	Slightly Agree	Neither Agree nor Disagree	Slightly Disagree	Moderately Disagree	Strongly Disagree
1	2	3	4	5	6	7

1. If I had a daughter, I would discourage her from working on cars
   1 2 3 4 5 6 7
2. I get angry at women who complain that American society is unfair to them.
   1 2 3 4 5 6 7
*3. Our society puts too much emphasis on beauty, especially for women.
   1 2 3 4 5 6 7
4. Women shop more than men because they can't decide what to buy.
   1 2 3 4 5 6 7
5. Most women's libbers are hopping on the bandwagon to protest just for the fun of it.
   1 2 3 4 5 6 7
*6. It bothers me when a man is interested in a woman only if she is pretty.
   1 2 3 4 5 6 7
7. It bothers me to see a man being told what to do by a woman.
   1 2 3 4 5 6 7
8. I think that having children is a woman's greatest fulfillment.
   1 2 3 4 5 6 7
9. Men are instinctually more courageous than women in the face of danger.
   1 2 3 4 5 6 7
10. I think that women should spend a lot of time trying to be pretty.
   1 2 3 4 5 6 7

* 11. I can really understand why there needs to be a woman's liberation movement.

1 2 3 4 5 6 7

12. Women rely more on intuition and less on reason than men do.

1 2 3 4 5 6 7

13. Women should not be as sexually active before marriage as men.

1 2 3 4 5 6 7

* 14. Men are just as easily influenced by others as women are.

1 2 3 4 5 6 7

15. I think women should be more concerned about their appearance than men.

1 2 3 4 5 6 7

16. Men will always be the dominant sex.

1 2 3 4 5 6 7

* 17. I dislike it when men treat women as sexual objects.

1 2 3 4 5 6 7

18. I think that the husband should have the final say when a couple makes a decision.

1 2 3 4 5 6 7

* 19. Women should have all the same rights as men.

1 2 3 4 5 6 7

*20. I see nothing wrong with a woman who doesn't like to wear skirts or dresses.

1 2 3 4 5 6 7

21. Women should be handled gently by men because they are so delicate.

1 2 3 4 5 6 7

*22. Women should be prepared to oppose men in order to obtain equal work.

1 2 3 4 5 6 7

23. I am suspicious of a woman who would rather work than have children.

1 2 3 4 5 6 7

24. I think that women are naturally emotionally weaker than men.

1 2 3 4 5 6 7

*25. On the average, women are as intelligent as men.

1 2 3 4 5 6 7

*26. If a husband and wife both work full time, the husband should do half of the housework.

1 2 3 4 5 6 7

*27. I like women who are outspoken.

1 2 3 4 5 6 7

28. I see nothing wrong with men whistling at shapely women.

1 2 3 4 5 6 7

29. It bothers me more to see a woman who is pushy than a man who is pushy.

1 2 3 4 5 6 7

30. A working wife should not be hired for a job if there is a family man who needs it.

1 2 3 4 5 6 7

*31. Women can handle pressure just as well as a man can when making a decision.

1 2 3 4 5 6 7

32. Men are naturally better than women at mechanical things.

1 2 3 4 5 6 7

33. A woman's place is in the home.

1 2 3 4 5 6 7

*34. I think that many TV commercials present a degrading picture of women.

1 2 3 4 5 6 7

*35. I think a woman could do most things as well as a man.

1 2 3 4 5 6 7

36. I think that men are instinctually more competitive than women.

1 2 3 4 5 6 7

*37. I think women have a right to be angry when they are referred to as a "broad."

1 2 3 4 5 6 7

38. It would make me feel awkward to address a woman as "Ms."

1 2 3 4 5 6 7

39. I see nothing wrong with men who are primarily interested in a woman's body.

1 2 3 4 5 6 7

*40. If I had a choice, I would just as soon work for a woman as for a man.

1 2 3 4 5 6 7

Reproduced from Benson, P. L. & Vincent, S. Development and Validation of the Sexist Attitudes Toward Women Scale (SATWS), Psychology of Women Quarterly, 5(2), Winter, 1980, 280-281.

APPENDIX E

New York University
A private university in the public service

School of Education, Health, Nursing, and Arts Professions
Division of Nursing

429 Shimkin Hall
Washington Square
New York, N.Y. 10003
Telephone: (212) 598-3921

July 9, 1982

Ms. Carolyn M. Bell, MSN
4025 Centenary
Dallas, TX 75225

Dear Ms. Bell,

I am happy to let you utilize the Judgments about Nursing Decisions. I would however, like a copy of your results upon completion of your study.

It is important for you to know that the JAND does not measure moral reasoning, but rather, moral behavior. Moral reasoning can be measured by the Defining Issues Test - to which I have made reference in my May-June 1981 NR article.

Enclosed is a copy of the JAND and scoring instructions. As you see from the format of the tool, asking respondents what they would do in the situation is not a simple matter, and the format of the entire test would need to be changed. My advice to you is it is not worth doing. I have studied this matter following the publication of my article. The results are not reliable. The reason for this is that everyone seems to know what the proper action is, and checks that response. I discovered people cannot respond without bias when asked about their own behavior.

For the time being you can use the information in the above article on reliability and validity of JAND. I have written an article describing more fully the psychometric properties of the tool but can't release it yet until I hear the editorial decision from the journal where it is being reviewed. Write to me in a few months and I'll let you know.

The version of the JAND enclosed is revised from the one used in my earlier research reported in May-June NR (1981). I have determined that only Column B scores are reliable. I would have subjects take the entire test, but would use only the Colum B scores.

My best wishes.

Sincerely yours,

Shaké Ketefian, Ed.D., R.N., F.A.A.N.
Chairperson, Department of Advanced
Education in Nursing Science

SESQUICENTENNIAL CELEBRATION 1831 1981

SK/dsw
Enclosure

JUDGMENTS ABOUT NURSING DECISIONS

You will find six stories here where a nurse finds herself in a dilemma as to what to do. Various courses of action that a nurse might take are listed following each story; you will be asked to respond to each course of action.

There are times when a nurse may believe and think that s/he should, from a professional point of view, act in a certain manner, but because of various rules and other limiting factors that exist in an organization s/he may not always be able to act according to her/his belief. Recognizing this added dimension of conflict you are asked to respond to each action in two ways. First, respond in terms of its being professionally an ideal choice that a nurse might follow if there were no constraining factors present (Column A). Second, respond in terms of its being a realistic choice that a nurse is most likely to follow, considering possible constraints that may be present (Column B).

Different nurses will have different views on these matters, and it is your view that is sought for each of these stories, and for each of the nursing actions in Column A and in Column B. You need not feel that your answers have to be different for Column A than they are for Column B. They may be similar, or they may be different; it is your honest judgment in each instance that we seek.

Please note that the nursing actions listed are not mutually exclusive, in that taking one particular action does not mean that the nurse may not take any of the other actions listed.

A suggestion only: It may be simpler if you went through all the actions and answer Column A first, then went back to the list of actions and answer Column B.

At no time will your name be identified; your answers are never identified with your name. Please do not write your name on the questionnaire.

Nurses A and B

Story One

Nurses A and B, good friends, were working the night shift on a Pediatric unit. Johnny, a one year old patient, went into heart failure and was transferred to the ICU. Immediately after the transfer Nurse A told Nurse B that she (Nurse A) had made a medication error and had given Johnny a larger dose of digoxin than was prescribed. She said that she had not reported the error and did not intend to report it; she made it clear that she did not want Nurse B to say anything about it either. She said that she was talking to Nurse B in confidence and that it would be unethical for Nurse B to break this confidence.

We are interested in Nurse B's actions.

For each of the actions listed below, check yes or no: for Column A - whether she should do or not; for Column B - whether she is realistically likely to do or not.

NURSING ACTIONS:	Column A: Nurse B should do: Yes	Column A: Nurse B should do: No	Column B: Nurse B is realistically likely to do: Yes	Column B: Nurse B is realistically likely to do: No
1. If Nurse A is basically a competent nurse, this one error can be overlooked; in that case, Nurse B will not do anything.	___	___	___	___
2. Nurse B explains to Nurse A the meaning of professional responsibility and accountability and suggests that she immediately report the error to the ICU staff and Johnny's physician.	___	___	___	___
3. After Nurse A states she will do nothing, Nurse B calls the ICU anonymously. She tells of the overdose, and hangs up.	___	___	___	___
4. Nurse B discusses the matter with the charge nurse and seeks advice as to what she should do.	___	___	___	___
5. Nurse B explains to Nurse A that when a patient's life is endangered, information on a drug overdose cannot be considered confidential.	___	___	___	___
6. Nurse B examines the chart for drug dose recorded, and for other relevant facts, so that she can evaluate the gravity of the error.	___	___	___	___

COMMENTS:

The Nephrologist and Nurse M

Story Two

Dr. Z, the chief nephrologist of a community hospital, constantly makes rounds on the dialysis unit visibly intoxicated, appearing dirty and disorganized. His speech is frequently slurred and inappropriate. His responsibilities include diagnosing patients and checking the patients on the unit for infection. Nurse M, a staff nurse, has noticed Dr. Z's behavior for a period of time and has approached both the head nurse of the unit and Dr. Z's partner to express her concern. She was told by both of them to mind her own business.

Nurse M has three school age children and she is the sole support of her family. She lives in a small close-knit community and is aware that Dr. Z and his wife are good friends with the Director of Nursing and her husband. The community hospital where Nurse M works is the only agency where she can work within a 75-mile radius.

We are interested in Nurse M's actions.

For each of the actions listed below, check yes or no: for Column A - whether she should do or not; for Column B - whether she is realistically likely to do or not.

NURSING ACTIONS:	Column A: Nurse M should do: Yes	Column A: Nurse M should do: No	Column B: Nurse M is realistically likely to do: Yes	Column B: Nurse M is realistically likely to do: No
1. Call her professional organization to discuss her concerns and seek advice.	___	___	___	___
2. Write a factual letter to the medical board of the institution.	___	___	___	___
3. Request a transfer from the dialysis unit.	___	___	___	___
4 She need do nothing; it is not Nurse M's responsibility to "clean up" medical practice.	___	___	___	___
5. Write an anonymous and angry letter to the local medical society complaining about Dr. Z's behavior.	___	___	___	___
6. Encourage the patients to complain to Dr. Z and his partner about Dr. Z's behavior.	___	___	___	___
7. Speak to Dr. Z privately and express concern about his health and patient safety.	___	___	___	___

COMMENTS:

Mrs. J and Nurse D

Story Three

Mr. J has been in ICU for a total of 11 days and comatose for the past seven days. His family was allowed to visit him only for short periods of time. His vital signs faltered and emergency treatment measures were stepped up, to no avail. A few minutes later Mrs. J arrived and was informed of her husband's death by an intern on duty. The intern then immediately asked Mrs. J to sign a permit authorizing an autopsy. She refused. The chief resident then tried to convince her that the autopsy would aid medical science and pressed further for her permission. However, she continued to refuse. The attending physician stepped in and also pressed her to sign the autopsy permit. Mrs. J replied that she wanted her husband to have the dignity she felt he was denied in his last few days in ICU. Mrs. J then asked to talk privately to Nurse D who had taken care of Mr. J during the last several days of his life.

The nurse felt the need to support Mrs. J in her refusal to sign the consent form because she viewed her professional responsibility to be toward the patient and his family. She also realized that an autopsy was against the J family's basic beliefs. On the other hand, the nurse, as a professional, is not against having autopsies performed because they are of value in research.

We are interested in Nurse D's actions.

For each of the actions listed below, check yes or no: for Column A - whether she should do or not; for Column B - whether she is realistically likely to do or not.

NURSING ACTIONS:	Column A: Nurse D should do: Yes	Column A: Nurse D should do: No	Column B: Nurse D is realistically likely to do: Yes	Column B: Nurse D is realistically likely to do: No
1. Explain to Mrs. J why an autopsy is important and suggest she discuss the matter with her family before making a decision.	___	___	___	___
2. Suggest to Mrs. J that the doctors worked very hard on her husband and that they deserve to do the autopsy.	___	___	___	___
3. Suggest that Mrs. J discuss the matter with the hospital chaplain and offer to call the chaplain.	___	___	___	___
4. Allow Mrs. J to discuss how she feels about consenting and explore her reasons. Whatever decision Mrs. J finally makes, the nurse supports.	___	___	___	___
5. Contact the nursing supervisor and let her talk to Mrs. J.	___	___	___	___
6. Suggest to Mrs. J that if the autopsy is performed Mr. J's death will not have been in vain in that it may help other people.	___	___	___	___
7. Tell Mrs. J that she (Nurse D) finds herself in conflict. She feels supportive of Mrs. J but also thinks there is merit in allowing an autopsy.	___	___	___	___

COMMENTS:

Mr. G and Nurse H

Story Four

Mr. G has had cancer for some time; he has been aware of his diagnosis and was dealing with it quite well. Mr. G was admitted to the hospital for recurrence of cancer.

The physician in charge wanted to test an experimental cancer drug on Mr. G and was trying to convince Mr. G that he would be helped by the "new drug." The nursing and medical staffs on the unit knew that Mr. G's questions were not answered truthfully by his physician. They also knew that this physician's prime interest was to test the drug through further research, and he was intent on getting Mr. G as a subject, through whatever means.

Mr. G was being asked to sign a consent form, and while he was not fully informed as to what this meant, because of his prior trust in his physician and his fear that saying no would put his care in jeopardy, he was considering signing it. He shared these thoughts with his nurse (Nurse H), and asked questions about the drug and what she thought he ought to do.

We are interested in Nurse H's actions.

For each of the actions listed below, check yes or no: for Column A - whether she should do or not; for Column B - whether she is realistically likely to do or not.

NURSING ACTIONS:	Column A: Nurse H should do: Yes	Column A: Nurse H should do: No	Column B: Nurse H is realistically likely to do: Yes	Column B: Nurse H is realistically likely to do: No
1. Contact her head nurse and supervisor and discuss her concern that an experimental drug may be given without a patient's informed consent.	___	___	___	___
2. Reassure Mr. G that his physician has the situation under control and is acting in his best interest.	___	___	___	___
3. Contact the chairperson of the research committee of the institution and alert him that an experimental drug may be given without the patient's full understanding and informed consent.	___	___	___	___
4. Suggest that she will arrange a meeting involving the patient, the physician and herself so that Mr. G can have his questions answered. She subsequently calls the physician and arranges such a meeting.	___	___	___	___
5. Tell Mr. G that he is going to get better with the drug and to stop worrying.	___	___	___	___
6. Write an anonymous letter to the research committee of the institution complaining that Mr. G's physician is coercing Mr. G to consent to an experimental drug without fully informing him about it.	___	___	___	___

COMMENTS:

Katie and Nurse P

Story Five

It was a holiday weekend on a fairly busy 30-bed pediatric ward with several recent post-op and acutely ill patients. Two registered nurses and one aide were on duty. Everything was under control until 6-year old Katie was admitted as an emergency. She had severe head trauma and required neurological checks every 15 minutes. Katie's parents were with her, visibly anxious about her.

The nurse in charge, Nurse P, assessed the unit to be dangerously understaffed and felt that additional coverage would be necessary to safeguard the patient's life. Nurse P called several staff members who were off-duty, but no one was available to come in and work on the unit at that time. This was not the first time that short staffing had caused an unsafe situation.

We are interested in Nurse P's actions.

For each of the actions listed below, check yes or no: for Column A - whether she should do or not; for Column B - whether she is realistically likely to do or not.

NURSING ACTIONS:	Column A: Nurse P should do: Yes	Column A: Nurse P should do: No	Column B: Nurse P is realistically likely to do: Yes	Column B: Nurse P is realistically likely to do: No
1. Notify the resident that due to Katie's condition and low staff-patient ratio it would be advisable to move Katie to the pediatric ICU.	___	___	___	___
2. Tell the parents, "If Katie were my child, I wouldn't leave her here."	___	___	___	___
3. Tell the supervisor that the situation is impossible and that she (Nurse P) is going to go home.	___	___	___	___
4. Rearrange all priorities, deal with the immediate crisis, then write up the situation and send it to the administrator so that this will not occur again.	___	___	___	___
5. Discuss the situation with the supervisor and explore ways in which she may be of assistance, such as by sending a nurse from another unit or by personally helping with care of patients.	___	___	___	___
6. Contact the supervisor and inform her that safe care cannot be assured and that she (Nurse P) will not accept any responsibility.	___	___	___	___

COMMENTS:

SK:so

Mr. T and Nurse L

Story Six

Mr. T, a 72 year old man, was diagnosed as having advanced cancer of the larynx; he is scheduled for surgery which he knows is not curative but which may prolong his life.

Prior to surgery, Mr. T became withdrawn and introspective. He told Nurse L he was not sure he wanted to go through with surgery; that his thoughts were that he had had a satisfying and long life, and felt he could accept death. He asked Nurse L to advise him as to what he should do.

Nurse L finds herself in a conflict. She believes that she must do everything possible to sustain life, but she also feels that patients have a right to make decisions about their own lives.

We are interested in Nurse L's actions.

For each of the actions listed below, check yes or no: for Column A - whether she should do or not, for Column B - whether she is realistically likely to do or not.

NURSING ACTIONS:	Column A: Nurse L should do: Yes	Column A: Nurse L should do: No	Column B: Nurse L is realistically likely to do: Yes	Column B: Nurse L is realistically likely to do: No
1. Remove herself from the situation. Ask to have her assignment changed.	___	___	___	___
2. Help Mr. T. problem solve, assess his fears and understanding of the implications of having or not having surgery.	___	___	___	___
3. Support Mr. T in whatever decision he makes.	___	___	___	___
4. Tell Mr. T he should have the surgery.	___	___	___	___
5. Talk to Mr. T's family members and ask them to convince him to have surgery.	___	___	___	___
6. Acknowledge Mr. T's right to decide either way, as well as his right to change his mind later. Assure Mr. T that care will be available to him in either case	___	___	___	___
7. Suggest a conference with Mr. T, his family, herself and the physician to discuss the matter.	___	___	___	___

COMMENTS:

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SCORING THE JUDGMENTS ABOUT NURSING DECISIONS

(DRAFT)

A manual for the JAND has not yet been prepared. In response to numerous requests on the part of individuals who wish to use it, I have prepared this material for interim reference by users.

The JAND is now a six-story, self-administered instrument; it yields two scores (Total) for each subject- one score for Column A (normative-should do), one score for Column B (categorical-realistically likely to do).

Scoring is quite simple, and here is how it goes: the "correct" answer (as determined by a panel of expert judges) gets a weight of 1, the incorrect answer, a weight of 0; this is the same for column A and for column B. Sometimes "yes" is correct, sometimes "no" is correct. See below.

Story number	Items where "yes" is correct	Items where "no" is correct
One (6 items)	2, 4, 5, 6	1, 3
Two (7 items)	1, 2, 7	3, 4, 5, 6
Three (7 items)	1, 3, 4, 5, 7	2, 6
Four (6 items)	1, 3, 4	2, 5, 6
Five (6 items)	1, 4, 5	2, 3, 6
Six(7 items)	2, 3, 6, 7	1, 4, 5

A practical note: I have found that the simplest way to go at this is, in the initial coding of the JAND- on fortran sheets and on IBM cards- to punch 1 for yes, 0 for no. Then, in the program, include a RECODE statement, reversing the score for the items listed on previous page where the "no" answer is correct- (0=1)(1=0).

Another thought: Since the items in this tool are not listed or numbered 1-39, but rather, 1-6 or 1-7 for each story, I have kept them that way in the analysis process. I have labeled the stories A, B, C, D, E, F. I have also given a label of SH for column A (stands for should do), and a label of R for column B (stands for realistically likely to do). This way it is at all times easy to identify the column, the story, the item. (Thus, SHA5 refers to column A, story one, item #5; RC2 refers to column B, story three, item #2).

In return for granting permission to investigators to use the JAND, I would like to request a copy of the research report upon completion of a project- both descriptive statistics on the JAND, and any relationships observed with other variables.

For the process of the development of the JAND please refer to my article in the May-June 1981 issue of Nursing Research - even though there is some new information on the reliability and validity of the present version of the JAND, it has not been published yet.

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