POWERLESSNESS AMONG STAFF NURSES EMPLOYED IN AUXILIARY AND NURSING SERVICE DEPARTMENTS

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We hereby recommend that the Thesis prepared under our supervision by Joanna V. Po entitled Powerlessness Among Staff Nurses Employed in Auxiliary and Nursing Service Departments be accepted as fulfilling this part of the requirements for the Degree of Master of Science.

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DEDICATION

This thesis is dedicated to my husband, Tony, and our two daughters, Joanne and Jeanne. Their encouragement, support, patience, and assistance enabled me to continue and complete this study.

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CHAPTER 1

INTRODUCTION

The improvement and survival of nursing as a profession is based on the ability and desire of nurses to use power. Nurses must work with other nurses to use power, become a cohesive group, and attain common goals. As a cohesive group with power, nurses will have impact on the decisions and policies affecting the health care profession. According to Kramer (1974) and Archer and Goehner (1982), the failure or inability of nurses to use power positively leads to the feeling of powerlessness and eventually to the abandoning of nursing as a profession.

As a profession, nursing has been placed in a dependent, subordinate relationship with the medical profession. The expectations of nurses have been that they be ladylike at all times, follow orders, be obedient assistants, and perform all of the menial work involving total patient care. According to Heide (1976), nurses as health care providers have been kept powerless by men in medicine and hospital administration, resulting in an inhibited growth of nursing as a profession.

Leib (1978) indicated that the core of powerlessness within the nursing profession consists of the overwhelmingly

female composition, lack of autonomy and the fact that nursing was molded to the needs of a predominantly male medical profession and hospital administration. Hassenplug (1976) suggested that as practitioners within a female-dominated profession, nurses have been taught to dedicate themselves to the service of others, to do what hospital administrators decree should be done and to refrain from revealing the doctor-nurse games they play lest they cause undue disturbances. Traditionally, according to Stevens (1983), "nursing embodies the female expressive role of maintenance of order and of caring for others" (p. 5). In accepting this role the nurse maintains the status quo wherein she stays in a low-risk position with less accountability.

In addition to the dominance by the medical profession, staff nurses within the hospital setting are thrown into a powerless role, partially due to a violation of the unit of command principle. According to Zungolo (1968), nurses relate to two lines of authority, that of the hospital administrator and that of the physician. Mundinger (1980) stated that within this two-part system, administrators provide the nursing service to patients and the physicians direct the daily medical activities of nursing personnel. In the organizational hierarchy, the staff nurse is on the

bottom line and decisions are made for her by the people above her.

According to Harragan (1978), women as nurses are at a disadvantage because of their limited knowledge regarding the games and rules of corporate politics. The resulting feelings of powerlessness inhibit the growth of nursing as a caring profession. The feelings are magnified as staff nurses are controlled not only by physicians, but by stringent administrative policies, clinical area managers, head nurses, and at times, the patient and the family.

Kelly (1978) envisioned the powerless nurse as a captive nurse: "a nurse who exists in a conceptual imprisonment held professionally immobile by outmoded concepts of her role" (p. 468). These feelings of powerlessness not only inhibit the growth of nurses, but are reflected in a deleterious manner to the ultimate victim--the patient. Patients who enter the health care system for help feel powerless in a sense that they submit themselves to the rules and regulations of the hospital, lose control of their environment, and in a way become conceptually imprisoned. According to Miller (1983), the uncertainty that the patients feel regarding their illness, especially a chronic illness, stimulates patients to feel that they lose the ability to control what is happening to them. She further

noted that if this feeling of powerlessness continues and is not stopped, a cycle of low esteem, depression and hopelessness can occur. These feelings could further lead to physiological and psychological regression. She also supported the belief that hopelessness is communicated by staff to patients and by patients to staff.

Horney (1945) pointed out that a hopeless attitude is deleterious not only to the patient, but also to the care provider. The same belief was held by Nadelson (1977) who speculated that a patient's continued physiological and psychological regression was due to withdrawal of active participation by the care provider, resulting in the clients' failure to continue trying. Kramer (1974) stated that the nurse who perceives a discrepancy between the school and work settings experiences a reduction in the commitment to quality nursing care, to the clients of health care, and eventually, to retention of membership in the profession.

According to Stevens (1983), the nurse's feelings of powerlessness are the result of multiple experiences. Some are clinically related, others result from disparity in values and personal and organizational circumstances. Kramer and Schmalenberg (1977) stated that nurses attempt to face such experiences by "adapting fully to the new

subculture, by fleeing the work scene, or by job hopping" (p. ix). According to Kramer and Benner (1972), with advancement in medical technology, nurses are turning to special care and auxiliary units to practice nursing: (1) to get away from the unchallenging nursing practice in the general nursing units; and (2) to be able to practice the type of nursing that they learned in school.

Specialization in nursing practice has progressively increased as technical and medical advances have occurred. According to the American Nurses' Association (ANA)(1980), the number of nurses who specialize in nursing practice is indicative of the fact that nurses have moved from a broad to a more specific way of looking at the profession and its practices. This specialization in nursing practice provides career opportunities, both in special care and auxiliary units, for those who look for further advancement. Better utilization of their abilities as well as increased responsibility and authority in practice is increasingly possible in these units. In an effort to study the effects of one type of specialization on the practice of nursing and the delivery of health care services, the investigator was prompted to study the perceived feelings of power or powerlessness among staff nurses employed in the auxiliary departments versus the nursing service departments.

According to the ANA (1980), the non-specialty nurses are those who provide general nursing care. The care they provide is available to patients wherever they may be at a given point in time and whatever their condition with regard to their health, disease, illness, or injury at that time. In contrast, special care and auxiliary unit nurses are those who provide specialized care to those patients who need extensive care, supervision prior to, during and immediately after the diagnostic and therapeutic procedures; and beyond the customary general nursing care. Lewandowski and Kramer (1980) stated that special care unit nurses possess a unique body of knowledge and have often taken specialized training. They frequently have a higher degree of autonomy and independence than those nurses in non-specialty settings. Lewandowski and Kramer (1980) further stated that specialty care and auxiliary unit nurses often work in groups using group cohesiveness, group-shared norms, and team effort to care for patients who require extensive care and supervision. Nurses in non-specialty units frequently work in greater isolation and, in the face of the less critical nature of their patient population, team effort is not as apparent. Furthermore, the special care and auxiliary unit nurses usually have achieved a complementary working relationship with physicians and frequently are paid higher salaries for their increased expertise and skills.

As medical and technical advancement continues, more and more nurses are seeking job opportunities outside of the traditionally structured nursing areas and turning toward auxiliary nursing departments. As a result, these nurses have acquired a higher level of expertise. Nurses in auxiliary departments can attain and maintain power because clients, physicians, and allied health professionals are dependent on them for their knowledge and expertise. The general duty nurses often cannot claim such power, and when they do, it is only in a limited capacity. Potentially there could be differences in the feelings of power or powerlessness between these two groups of staff nurses.

Statement of the Problem

This study was prompted by an interest in identifying the work settings and therefore type of management within the hospital environment in which staff nurses perceive greater feelings of powerlessness. The following question was asked: Is there a difference in the feelings of powerlessness among staff nurses employed in auxiliary and nursing service departments?

Justification of the Problem

Researchers such as Clark (1959), Pearlin (1962), Neal and Rettig (1963), Lipsitz (1964), Seligman (1964), and

Smith (1968) have shown that feelings of powerlessness are related to dissatisfaction both with the work itself and with the work organization. Kanungo (1982) stated that this dissatisfaction leads to "worker apathy, deliberate sabotage, high rates of absenteeism among all categories of employees, union strikes, and work-to-order campaigns" (p. 5). Kramer (1974) noted that eventually many nurses totally leave the profession.

According to Kanungo (1982), dissatisfaction involves negative job feelings, eventually leading to alienation which is equivalent to powerlessness. Furthermore, Kanungo stated that "work alienation is a form of dissatisfaction or a feeling of disappointment with jobs, occupations, or work in general, which do not provide intrinsic need satisfaction or opportunities for self-direction and self-expression" (p. 21). This definition was expanded by Blauner (1964), who stated that the employees feel alienated or powerless when they are not capable of controlling their work processes. Thus they fail to become actively involved in work as a mode of self-expression.

The social, economic, and political histories of nurses and women in general provide a strong basis for powerlessness and lack of freedom in the nursing profession. According to Ashley (1975a), "only by understanding

nursing's history can nurses break the oppressive chains of the past" (p. 1467). By learning about past developments in nursing, one can identify chronic weaknesses, learn from them, and identify and implement ways to change the persistent state of patriarchy of the health care industry in the United States.

Ideally, the ultimate goals of nurses include the highest quality of wellness possible for all. By creating an environment for themselves and for their patients wherein all individuals have freedom to express themselves openly and honestly and to be respected for that expression, a high level of wellness will be achieved. But, to be advocates for themselves and others, nurses must recognize their own potential, be willing to take risks to stand up for themselves, and to realize that individuals can affect change to facilitate the quality of health care. Historically, nurses have not been risk takers and have had difficulty influencing others.

Nurses have not been recognized by the public as a separate group equal to medicine or law. They are not asked to participate in political activities and are not consulted on public issues to the same degree as others. According to Deloughery and Gebbie (1975), in order to be perceived as an independent viable group, nurses must break out of their

traditional roles. Since these roles are deeply embedded in our society, change must take place within people, women and men alike.

The implications of the history of women and of nursing are tremendous. Nurses should become knowledgeable about economics in order to provide evidence for more adequate salaries. Awareness regarding the cost and utilization of goods and services within an institution would provide nurses with important data toward this endeavor. If nurses effectively present this information to the appropriate individuals, it could be used as the basis for justifying their own salary increases, as well as the correction of wasteful or dishonest practices within the health care organization.

The socialization of nurses through education and/or conditions of employment could lead to powerlessness and lack of freedom within the health care institutions. The intent of this investigator was to assess the perceptions of nurses regarding their level of power. If, because of socialization, nurses do not think that they have an equal voice in decision-making and the development of policy, they may not demand to participate in these activities. On the other hand, if nurses do perceive potential or actual control over their environment, they are more likely to be

involved in voicing their ideas to promote professional integrity, identification, and autonomy.

In summary, there are many factors that can hinder or magnify the nurses' feelings of powerlessness. Factors such as the social, economic, and political histories of nurses and women in general provide a strong basis for powerlessness and lack of freedom in the nursing profession. For the nursing profession to grow and promote professional integrity, identification and autonomy, nurses must learn their past, identify their weaknesses, and work on areas that can change and influence their work settings. By so doing, nurses will be able to achieve and maintain power in order for the profession to grow and to achieve its ultimate goal of the highest quality wellness possible for all. Therefore, it is important that work settings in which the staff nurses perceive a high level of powerlessness be identified, recognized and prioritized.

Conceptual Framework

The conceptual framework was based on the concept of powerlessness by Seeman (1959). In his effort to integrate the different meanings of alienation, Seeman identified five variants of alienation. They are powerlessness, meaninglessness, normlessness, isolation, and self-estrangement. He further elaborated that each variant pertains to a

different and subjectively psychological being of the individual as a result of different environmental conditions. He frequently addresses powerlessness as an antecedent or component of alienation. Furthermore, according to Seeman (1959) and Pearlin (1973), the idea of alienation as powerlessness is the most frequently tested variant.

According to Seeman (1959), the concept of powerlessness was intended to explain and describe men's and women's relationships within a larger social order. His rationale behind this limitation was to prevent the concept from becoming too global and from becoming a measure of personality adjustment. In addition, his version of powerlessness does not include the value of control to the individual. He viewed powerlessness as a psychological state rather than sociological process.

Seeman (1959) indicated that powerlessness as a variant of alienation resembles Rotter's (1954) construct of locus of control. Rotter identified two types of people, internal and external. In 1966, Rotter noted that internally controlled people are conditioned to perceive themselves as capable of controlling their environment, while externally controlled people are conditioned to expect that a reinforcement is not entirely contingent upon one's own action but rather the result of luck, chance, fate, powerful

others, or a complex of force, surrounding them. According to Miller (1983), "locus of control is directly related to powerlessness and is a rather stable personality trait" (p. 36).

Seeman (1959) noted that although external control and powerlessness are similar concepts, they are generally not used to describe the same perception. In relation to social learning theory, the person's feelings of lack of control are related to performance. For example, Shepard (1971) described powerlessness at work as the "perceived lack of freedom and control on the job" (pp. 13-14). Blauner (1964) echoed a similar view when he said that "the non-alienated pole of the powerlessness dimension is freedom and control" (p. 16). Blauner stated that the feeling of powerlessness on the job is the result of the mechanization process and that workers find the resulting job environments inadequate.

Seeman (1959) defined powerlessness as the "expectancy or probability held by the individual that his own behavior cannot determine the occurrence of the outcomes or reinforcements he seeks" (p. 784). This expectancy was distinguished from the objective situation of powerlessness. According to Seeman (1959), the observers judge a particular situation against some ethical standards, and the individual's sense of discrepancy between the expectancy for

control and the desire for control. Kanungo (1982) added that work alienation in the form of powerlessness relates to the perception of lack of control over the individual's work situation. He stated that this perception of lack of control may lead to the feelings of powerlessness, and eventually may result in inhibited growth of the individual employees, including nurses professionally and personally, and the nursing profession as a whole.

The lack of studies in which nurses working in auxiliary and nursing service departments were compared led the investigator to consider the study of Lewandowski and Kramer (1980) who compared nurses working in specialty and non-specialty units. They claimed that specialty unit nurses possess a specialized body of knowledge and have often taken additional and specialized training to attain detailed and scientific knowledge. They indicated that these nurses were acknowledged as having specialized skills, competence, and as belonging to a specific professional group. Internal standards, coordination, and peer control are generally operative to a greater extent than in non-specialty settings, since nurses in these units are often left to coordinate their own activities. Furthermore, they contended that the nursing supervisors are less likely to exert control over the nurses who work in specialty areas

because the supervisors are usually less knowledgeable of what is going on than the nurse who works in that unit.

Auxiliary or specialty units also provide for complexity of tasks, permitting nurses working in these areas to achieve a high degree of freedom and self-control. Due to the nature and governance of the auxiliary or specialty units, nurses working in these areas have greater autonomy in their practice. A patient who is undergoing a diagnostic and/or therapeutic procedure, connected to a monitoring device or to a dialysis machine, experiencing a physiological and/or psychological crisis state, or immobilized is more dependent upon the health care personnel than are ambulating, decision-making patients often found in the general units. There are obvious group cohesiveness and group-shared norms in auxiliary or specialty units which are brought about by the usual closer geographic proximity to each other and the team effort in dealing with patients who require extensive care and supervision. On the other hand, nurses in general medical and surgical nursing areas generally work in isolation, and in the face of the less critical nature of the patient population, the team effort may not be as obvious.

In summary, the concept of powerlessness was identified by Seeman (1959) as an antecedent of alienation. He pointed

out that the idea of alienation as powerlessness is the most frequently tested variant and it is a psychological state. Consequently, the feeling of powerlessness or the inability to control one's destiny within the work environment may be amplified by lack of knowledge of control relevant information. In an institution, nurses at the staff level who work within diversified work settings may have several variables which may influence or hinder their feelings of powerlessness.

Assumptions

The following assumptions were made in this study:

1. Work alienation promotes feelings of dissatisfaction/disappointment and hinders the employee's opportunities for self-direction and expression (Kanungo, 1982).
2. Employees feel alienated or powerless when they are not capable of controlling their work processes (Blauner, 1964).
3. The application and utilization of specialized knowledge of staff nurses will vary according to their work environment (Lewandowski & Kramer, 1980).

Research Question

The research question was: Is there a difference in the feelings of powerlessness among staff nurses employed in auxiliary departments and staff nurses employed in nursing service departments?

Definition of Terms

For the purpose of this study, the following terms were conceptually and/or operationally defined:

1. Auxiliary departments: nursing units in which specific services are provided which cannot be accommodated within the realm of customary methods of nursing care. The patients from different nursing units are brought to these areas to use the equipment, machinery and staff, and undergo diagnostic and therapeutic procedures. Units utilized in this study included: Circulatory Dynamics, Hemodialysis, Cardiology Diagnostic, Cardiac Rehabilitation, Internal Medicine, Hypertension, Peripheral Vascular, Pulmonary, and Radiology. The nurses working in these units were not under the auspices of nursing service.
2. Nursing service department: department containing non-specialty general nursing units in which patients are housed before and after their diagnostic and therapeutic procedures, and in which their needs may be met with the

customary method of nursing care. There is a limited amount of equipment and machinery on these units. The staff was under the auspices of nursing service.

3. Powerlessness: The "expectancy or probability held by the individual that her own behavior cannot determine the occurrence of the outcomes or reinforcements she seeks" (Seeman, 1959, p. 784). Operationally defined, powerlessness is the extent to which the health care workers perceived that they have limited or no control over events as measured by scores on Guilbert's Health Care Work Powerlessness Scale (Instruments, 1979).
4. Staff nurse: female registered nurse who had graduated with a diploma, associate degree, or bachelor of science degree, was employed full time in a hospital in a non-management position, and had worked in the present work area for at least 12 months.

Limitation

For the purpose of this study, the following limitation was identified: A small convenience sample was used, and therefore, the results may not be generalized beyond this sample.

Summary

Generally, due to the history of nursing, a lack of autonomy in practice and violation of unity of command in

the work setting, members of the nursing profession traditionally have been cast in a powerless role. Nurses have little independence, identity or authority, and lack autonomy. The violation of unity of command principle or the fact that the nurses have more than one boss, puts the nurse in a powerless position in dealing with the two-part system, the administration and the physicians. The identified problem for this study was to determine if there was a difference between staff nurses' feelings of powerlessness depending upon employment in the auxiliary versus the nursing service departments.

The conceptual framework is based upon Seeman's (1959) work on alienation in which he considered powerlessness as the primary concept among five variants of alienation. He defined powerlessness as the "expectancy or probability held by the individual that his own behavior cannot determine the occurrence of outcomes or reinforcements he seeks" (p. 784).

Although nurses at the staff level may be subject to feelings of powerlessness, identified situational factors within the hierarchical structure of the institution, together with the diversity of control-relevant knowledge and complexity of tasks, may serve to alter their perceptions. The research question was stated as: Is there a difference in the feelings of powerlessness among staff

nurses employed in the auxiliary departments and staff nurses employed in nursing service departments.

A study to identify work areas in which staff nurses succumb to high feelings of powerlessness was considered to be warranted. This statement was justified by data from studies which support a relationship between powerlessness and dissatisfaction, not only with one's work, but with the work organization as well.

CHAPTER 2

REVIEW OF LITERATURE

The review of literature is divided into two parts. The first part contains literature related to the concept of power and powerlessness. The second part includes literature related to powerlessness in the nursing profession. The second part was subdivided into categories of historical factors, organizational factors, personal and professional factors, and the public image factor related to powerlessness in nursing.

The Concept of Power

The word power comes from the Latin posse, which means "to be able" (Random House, 1973, p. 1040). May (1972) described power as the ability to affect, to influence, and to change other persons. He further identified five levels of power that are present as potential in every human being. They are: (1) the power to be, (2) self-affirmation, (3) self-assertion, (4) aggression, and (5) violence. May (1972) contended that power cannot be given to another person; that it must be assumed, taken or asserted. This statement is based on the idea that power is actualized in conditions in which conflicts emerge. In this condition, an

aggressive act by a participant leads to an effort by the participant to reach a resolution about the conflict. Aggression is viewed as constructive when confrontation is not intended to hurt but to penetrate the consciousness of others, to ward off powers that threaten one's integrity, or to actualize one's own self and one's own ideas in a hostile environment.

According to May (1972), there are five types of power within individuals. They are: (1) exploitative, (2) manipulative, (3) competitive, (4) nutrient, and (5) integrative power. The first two, exploitative and manipulative power, are considered to be destructive types. Exploitative power is linked with force and is viewed as the simplest and most destructive type. It is the type of power in which individuals submit themselves to the person who holds the power. Manipulative power is the second destructive type. It is the type of power in which individuals submit themselves out of desperation or anxiety to the person who holds power. The next three types of power reflect a constructive rather than a destructive focus. Competitive power is the type of power in which individuals gain from an opponent's loss rather than from their own merit. Nutrient power is a power for the other which develops out of one's concerns for the welfare of the whole group. It is similar to the

parent's care for the child. The last type, integrative power, is viewed as power with another person which abets the other's power, creating a growth-producing condition. May (1972) stated that "the goal for human development is to learn to use these different kinds of power in ways adequate to the given situation" (p. 112).

French and Raven (1960) viewed power in a social context. They identified five bases of power possessed by a social agent or influencing agent. They are: (1) reward power; (2) coercive power; (3) legitimate power; (4) referent power; and (5) expert power. According to French and Raven, reward power is based on the individual's perception that the social agent has the ability to mediate rewards. Conversely, coercive power is based on the individual's perception that the agent has the ability to mediate punishment. Legitimate power arises from the individual's values. The individual perceives that the social agent has a legitimate right to prescribe behavior. Referent power is based on an individual's identification or feeling of oneness with the social agent. Expert power is based on the perception that the agent has some special knowledge or expertise.

French and Raven (1960) proposed several hypotheses related to the five types of power. One of these hypotheses is stated as the stronger the basis of power, the greater is

the power. Therefore, if an individual perceives a social agent as possessing several bases of power, the individual perceives increased levels of power in the agent.

Stevens (1983) identified two categories of power sources in the nursing profession, namely: (1) professional bases, and (2) personal bases. Professional power bases come from groups, for example, nurses who belong to professional organizations and share common goals for the improvement of the profession, while personal bases of power center on the "ability to portray self-confidence, self-esteem and competency, including that of making decisions, value clarification and assertiveness" (p. 17).

Korda (1975) described life as a game of power. The aim of the game is to know what you want and to get it. Yet, most individuals never obtain power because they do not like to accept that they want it. Those individuals who do have power may cover up the fact and pretend that they have none. Disclosure of the possession of power would force them to be responsible for using it. According to Korda (1975), "safety lies in an artfully contrived power of impotence, behind which one can do exactly as one pleases" (p. 7).

According to Ashley (1976a), "power corrupts and absolute power corrupts absolutely" (p. 5). The corollary

to this is that powerlessness corrupts also by threatening the integrity and hindering the growth of the individual both professionally and personally. In addition, according to Claus and Bailey (1977), the ability to use power implies the ability to lead and influence others. The corollary to this is that the inability and unwillingness to use power lead to powerlessness. Attributes which influence power are the same as those which can lead to feelings of powerlessness. Therefore, the concepts of power and powerlessness can be viewed as opposite ends of a continuum.

The Concept of Powerlessness

Klein (1966) viewed the concept of powerlessness as a variant of alienation. The word alienation is derived from the Latin word alienare, which means to cause a separation to occur. Alienation has been used by theologists, politicians, and sociologists. According to Kanungo (1982), the members of each group defined the word "alienation" to fit their own situation. From the theologist's point of view, alientation means a state of separation from God; to the politicians, it means transfer of ownership; and to the psychologist, it means the complete surrender of the individual.

In 1982, Kanungo conducted an extensive review of literature on the phenomena of work alienation and

involvement. He claimed that these phenomena play a vital role in "the social and economic climates of contemporary post-industrial societies" (p. Preface). In addition, he said that understanding the phenomena themselves, their causes, and consequences is considered vital for the improvement of the quality of life of the workers and the effectiveness of the organization in which they are employed. Kanungo (1982) stated that the sociologists Hegel and Marx worked together in providing the intellectual foundation for an understanding of the problem of alienation in modern society. He claimed that Hegel identified the basic psychological state of alienation in individuals' spiritual lives while Marx identified alienation in individuals' material working lives.

Kanungo (1982) indicated that since Marx' (1932) last publication, there have been multiple social scientists who viewed work alienation as the result of inadequate opportunity within organizations for workers' to satisfy their needs for personal control, autonomy, and self-actualization. He defined alienation as "a perceived lack of control over important events that affect one's life" (p. 24). He further noted that the individual is in a state of alienation when he has lost his individuality. Alienation manifests itself in various forms and most of the time it

affects all levels within the organization. Some of the manifestations of alienation, according to Kanungo, are worker apathy, sabotage, increased absenteeism among all categories of employees, union strikes, and work-to-order campaigns.

Pappenheim (1959) also discussed Marx' contributions toward defining alienation. He stated that the term alienation was incorporated into sociological theory in the 19th century, when Marx used the concept of alienation in his interpretation of the capitalist era.

According to Cummings and Manring (1977), there is no reported consensus as to whether alienation is a unitary concept or a construct with multi-dimensional variables. However, attempts have been made to define it. Seeman (1959) defined powerlessness as the "expectancy or probability held by the individual that his own behavior cannot determine the occurrence of the outcomes of reinforcements he seeks" (p. 784). In 1959 and again in 1972, Seeman identified a total of five variants of alienation. These variants include powerlessness, meaninglessness, normlessness, value isolation, and self-estrangement. According to Seeman (1959, 1971), each variant pertains to a different and objectively felt psychological being of the individual as a result of different environmental conditions.

Powerlessness is frequently addressed as an antecedent or component of alienation. As indicated by Seeman (1959) and Pearlin (1973), powerlessness as a form of alienation is the most frequently tested variant. Powerlessness was defined by Seeman (1959) as the individual's low level of expectancy for control of events. This expectancy was distinguished from the objective situation of powerlessness as observers saw it; the observer's judgment of that situation against some ethical standards; and the individual's sense of a discrepancy between the expectancy for control and the desire for control.

Seeman (1967b), in his investigation of the powerlessness-learning connection, conducted several studies with manual and non-manual workers as subjects. Seeman (1963, 1967a, 1967b) reported an inverse relationship between feelings of powerlessness and knowledge of control-relevant information. His 1963 study was conducted in a reformatory setting. It included 85 inmates who met the set criteria which were: (1) an intelligence quotient of at least 100, and (2) a ninth grade education. The study was designed to examine the relationship between alienation and social learning in a reformatory setting. Four types of data were obtained: (1) the alienation measures, (2) indexes of learning for several kinds of corrections-relevant

information, (3) social/desirability measure, and (4) background information, including data related to their criminal career, IQ, and achievement test scores. The results of this study indicated that the inmates who scored low in powerlessness showed superior retention of the parole material. This finding indicated that the individual had control over the events that were occurring. There were no significant differences in the inmates' backgrounds to warrant attributing the results to their differences in intelligence or criminal history. In addition, the data indicated that the unalienated prisoners learned more than the alienated individuals. In this particular study, Seeman (1963) concluded by stating that "a bureaucratic, specialized, and isolated individual becomes convinced of his own powerlessness, and turns his attention away from control-relevant learning: becomes politically apathetic and volatile, frantic in leisure; ignorant in international affairs" (p. 283).

In another study related to alienation and learning, Seeman (1967b) collected data on a longitudinal basis from college students in Sweden. This study was a replication and extension of work conducted in the United States on alienation and learning. The sample consisted of college students who entered the university in 1960. They were

interviewed then and again in 1962. The sample consisted of 343 students. They were tested on nuclear and cultural affairs. The findings of this study indicated that students who scored high in powerlessness had a poor knowledge of science. In cultural information, there was no difference between students who scored high (alienated) and low (unalienated) in powerlessness. In this study Seeman had shown that the powerlessness-learning hypothesis was applicable cross-culturally and was therefore applicable to multiple areas of control-relevant information such as nuclear war, reformatory life and health. He concluded by stating that "people who believe that the environment is one they can have an effect upon show that they are sensitive to potentially helpful cues about that environment whether those cues are matters of health, or parole, or of politics" (p. 121).

Seeman (1967a) randomly selected 558 men of the work force in Sweden and assessed powerlessness and political knowledge. The results indicated that both the manual and non-manual workers who scored high on the powerlessness scale scored lower on the objective test concerning political knowledge than those who had low powerlessness scores. In addition, Seeman found that alienation was "lower among those with high incomes, among those who stress the

intrinsic features of their job, and among those who express little interest in discussing their work with others" (p. 284).

Seeman and Evans (1962) surveyed 887 tuberculosis patients in a hospital. This was a quasi-experimental research study to determine the significance of alienation in social learning. The hypotheses were: a patient's feeling of powerlessness or personal control can influence his ability to learn about tuberculosis, and patients who experience high scores in powerlessness learn poorly. Their findings indicated that patients with high powerlessness scores had poor knowledge regarding health issues, while those who scored low in powerlessness were knowledgeable in this area.

Blauner (1964) studied the effects of technology and organizational structure on work alienation. In his book, Alienation and Freedom (1964), Blauner made a comparison of workers from different technological industries, namely, automobile, chemical, printing, and textile. He noted that these four industries differed in their degree of technological mechanization, division of labor, economic structure, and bureaucracy observed by the social organization. He reported a higher incidence of powerlessness among workers in the automotive and textile industries. He enumerated the

following situations in which workers are subjected to feelings of powerlessness: (1) when the workers are unable to influence or control the work process; (2) when the workers have no influence over employment, its terms, and the environment; (3) when workers are unable to influence the decision-making process of the leadership governing the employees; and (4) when workers realize that others have the power of decision-making (especially over their work). Furthermore, Blauner claimed that the craft technology of the printing industry and the continuous process technology of the chemical industry provided the workers with more freedom and work integration as opposed to the routine and mechanized assembly line of automobile and textile industries. In addition, he believed that worker alienation is the result of segmented workflow, routine jobs that were carried out at a steady pace, and work operations that were mechanically controlled.

Based on Blauner's statement that "freedom declines and the curve of alienation rises sharply in the period of machine industry" (p. 182), Tudor (1972) studied the relationships between job complexity and sense of powerlessness for the workers. His analysis was based on a nationally representative sample of non-agriculturally employed white males who were interviewed by the Survey Research Center in

its Election Studies in 1960 and 1964. He found that the lowest levels of powerlessness were experienced by those men with moderate and high incomes who had the highest job complexity and who were intergenerationally non-mobile or slightly mobile. Tudor defined intergenerational mobility as a comparison between the father's and son's occupational status.

Although Seeman and Tudor did not include members of the nursing profession in their research, the results may have application to the practice-oriented environment of nursing. Nurses are employed in a structured, bureaucratic environment being controlled by the two-boss system, the administrators and the physicians. Therefore, the feeling of powerlessness, or the inability to control one's destiny within the work environment may also be amplified for nurses with lack of knowledge of control-relevant information, lack of freedom and autonomy.

According to Faunce (1968), those workers who feel powerless and perceive that the working area in meaningless and normless will not be concerned with the goals of the work organization. Therefore, workers will isolate themselves and feel alienated.

Naik (1978) conducted a study using bank employees. The findings indicated that female workers expressed greater

alienation than did their male counterparts. Demographics such as length of employment, years in present department, and years of previous experience were not found to be correlated with alienation. Factors such as job satisfaction and advancement were negatively correlated with work alienation; while motivation, competency, involvement, and consciousness showed a significant positive correlation with alienation. The worker's level of aspiration and intolerance for ambiguity were also significantly correlated with alienation scores. When Naik administered Rotter's I-E Scale to the workers, her findings indicated no relationship between scores indicating external control and scores on the work alienation scale; but there was a significant relationship between the worker's scores indicating external control and their scores on the general alienation scale. The authors concluded that the internally controlled individual was more alienated and experienced stronger feelings of powerlessness.

Kirsch and Lengerman (1972) conducted a study of white collar employees. Their sample was composed of computer personnel, clerical workers, and machine operators who were working in a bank. Their findings indicated that the machine operators expressed the highest levels of alienation and the computer personnel expressed the lowest levels.

They also found that work powerlessness was significantly related to self-estrangement as measured using the Alienating Conditions Scale. Furthermore, the workers who expressed the greatest alienation were young and educated.

Lystad (1972) reviewed several studies on alienation. He noted a frequent occurrence of alienation among: (1) white collar workers in highly centralized and formalized organizations, (2) white collar workers in economically marginal positions such as small businessmen, (3) workers in business abroad, and (4) employees with limited hope for advancement.

Aiken and Hage (1966) studied 314 professionals, including psychiatrists, social workers, and rehabilitation counselors, who were employed in 16 welfare organizations. They focused their study on centralization, formalization, and two types of alienation. They defined centralization as the degree to which employees participated in decision making. They defined formalization as the amount of work standardization and the amount of deviation permitted. The two types of alienation were: (1) alienation from work in which there was disappointment with one's career and development due to inability to fulfill professional norms, and (2) alienation from expressive relations which involves dissatisfaction in social relationships with supervisors and

co-workers. Their findings indicated that the highly centralized and formalized organizational structures were characterized by the presence of employees with greater alienation from work and alienation from expressive relations. They concluded that regardless of high salary and societal prestige, professionals become alienated from work when their organizational structure inhibits autonomy, participation, and involvement in the organizational goal setting. Furthermore, they stated that when the employees' professional efforts are inhibited, they tend to be dissatisfied with their jobs. They stated that work alienation had a tendency to be greater among professionals employed by organizations than among non-professionals employed by organizations.

Miller (1967) conducted a study on alienation of 335 professionals employed in a bureaucratic setting. He included non-supervisory scientists and engineers with master's or doctoral degrees who were employed in the aerospace industry in his sample. He found that work alienation was higher when the organization had a greater control over the activities of the professionals, including the type of supervisor, freedom of research choice, professional climate, and company encouragement. He also found that there was a relationship between work alienation and organizational

control over professionals who had advanced education. He concluded that alienation from work is the result of professional orientation in a bureaucratic setting.

Powerlessness in Nursing

In this section of the literature review, powerlessness in nursing is presented. According to Stevens (1983), there are many factors that influence nurses' feelings of powerlessness. Some of them are related to clinical practice, some to disparity in values, to organizational factors, and some to personal circumstances. In addition, nursing as a profession is predominantly composed of women who as a group have been historically oppressed and exploited. Archer and Goehner (1982) stated that "women are generally socialized to avoid risks, to shun conflict, to acquiesce to authority, and generally to keep a lower profile than are men" (p. 12).

According to Lewandowski and Kramer (1980), increased disparity between the staff nurse and her superiors, lack of a sense of achievement, dissatisfaction with work rewards, lack of group cohesiveness, and limited complexity which requires less freedom and self-control may affect these feelings. In their study of role transformation of special care unit nurses, they found that within an institution, nurses at the staff level who work within diversified work settings may perceive alterations in these factors which

influence their feelings of powerlessness. They indicated that nurses who work in special care units were more self-actualized than those nurses who worked on the other types of units.

Pearlin (1973) studied work alienation of 1,315 nursing personnel below the position of nursing supervisor. The study was conducted in a large federal mental hospital in the District of Columbia. He defined alienation as "subjectively experienced powerlessness to control one's work activities" (p. 314). Within the organizational hierarchy of the hospital, he found that some situations served to minimize these feelings of powerlessness while others served to intensify them. He indicated that when authority relationships (whether with nursing supervisory personnel or with physicians) are such as to hinder the reciprocal influence of subordinates, the feeling of powerlessness is magnified. According to Pearlin, other factors that are alienative in nature include limited achievement and dissatisfaction with work rewards. He also found that behavior based upon group-shared norms created a sense of personal commitment and voluntaryism instead of feelings of powerlessness. He concluded that when individual nurses were supported by group norms in the performance of work tasks, they were relatively protected from alienation. It is of

interest to note that those nurses who worked in isolation units and without outside social ties to fellow workers were found to be more prone to intense alienation or subjective powerlessness.

According to MacFarland and Shiflet (1979), nurses are among the professionals who are employed by organizations. There are certain elements that an organization of managers can provide for the professionals, such as "structured job opportunities, resources, planning, goals, and clientele" (p. 6). But, on the other hand, MacFarland and Shiflet noted that organizational managers are finding that professionals are hard to deal with because of their professionalism; they value professional interests such as "autonomy, independence, and peer evaluation more than organizational values such as loyalty, conformity, obedience, or subservience" (p. 6). In addition, they stated that professionals cannot be treated in the same way as the other employees because to them work is more valuable than the doctrine of bureaucracy. The conflict between organizational and professional values creates a condition wherein nurses employed in the hospital setting feel the loss of control over their work, resulting in feelings of powerlessness as a form of alienation.

Historical Factors Related to Powerlessness in Nursing

Nursing as a profession is comprised largely of women; therefore, many of the same issues that affect women in society have an impact on the nursing profession as well. Women have been known as a socially oppressed and exploited group. In 1912, Beard wrote that opportunities for women in special training were meager and considered avocational and temporary. According to Ashley (1975b), in the early 1900s, women virtually had no social or legal rights. Society did not promote employment for women. She further stated that even the efforts of women themselves were not directed to changing the social order, but to dealing with problems related to their own educational and professional development.

The Second World War brought about a rapid increase in the number of women in the work force. According to Chafe (1972), the public had shown general encouragement and approval of women in the work force, but their involvement in work outside of the home was considered as a temporary measure to meet a manpower shortage. They were denied management positions, were excluded from policy making bodies concerned with running the war, and were paid less for doing the same work as a man. Pollock (1972) noted that after the Second World War, women fell under the influence

of the feminine mystique which confirmed them as a function of someone or something else (Pollock, 1972). Women willingly stopped working, returned home and focused their attention on domestic activities such as cooking, cleaning, and serving. According to Archer and Goehner (1982), man became the breadwinner of the family and women were expected to be subservient to their husbands.

The 1950s, according to Chafe (1972), were viewed as an age when traditional values gained new energy and influence. Femininity and creativity in homemaking were stressed in the public media. In the 1960s, Chafe noted that the feminists were able to draw the public's attention to themselves and to raising America's consciousness to the inequalities which women suffered. The Equal Rights Amendment (ERA) was brought before the House of Representatives in 1970 with the purpose of obliterating sex as a functional classification within the law. In 1971, the ERA passed Congress and was sent to the states for ratification. According to Golick (1971), the ratification of this amendment would have indicated that the United States was committed to providing equality to all, regardless of sex. However, Golick indicated that the real problem that confronts women is not the legality of the law, but its social and psychological impact on women.

According to Chesler and Goodman (1977), "women have neither money or power," and "only the powerless live in a money culture and know nothing about money" (pp. 1, 271). They further stated that "to men, women are as universal a commodity as money" (p. 10). This situation can easily be identified in the history of nursing within health care organizations. Ashley (1973) commented that power and powerlessness are not new to nurses. In addition, she stated that nursing's movement toward professionalism could be described as a power struggle. This was manifested by: (1) the nurses' struggle to obtain an appropriate education; (2) the struggle for freedom to practice; and (3) the struggle to convince others of the value of nursing and its role in the health care community. Kalish (1978) stated that the critical challenge that faces nurses is how to achieve a solid resource and power base in order for the profession to move forward. Without this power base, the growth and advancement of the nursing profession will be crucially limited and nursing will face difficulty and hardship in attaining its true professional status.

Frank (1959) noted that the first influential schools of nursing for lay nurses were not hospital controlled. But the increased costs of education, the changing patterns of hospital economics, politics, opposition to higher

standards of education for nurses, and attachment to the almshouse of institutional control led to a compromise in which the training school became a department of the hospital. Once financing of the nurses' training was established by hospitals, repayment in services rendered by the trainees was expected. According to Frank, nursing was looked upon as a menial service and the nurse was often treated as, and classified with, a domestic servant. She further noted that the hospitals had a practice of recruiting students instead of hiring graduate nurses to staff the units due to the fact that they provided cheap labor and supported the growth of hospital businesses. The nurses in training were exploited and the graduate nurses frequently had difficulties finding jobs other than for private duty practice. Although the nurses were employed independently, they received the lowest income of all those listed in a 1945 comparison study of independent professions performed by the American Journal of Nursing ("American Nurses," 1946).

According to Frye (1966), nurses' low salaries were set within the hospital industry because it was the main market for nurses. She stated that capitalizing on the nurses' concern for the patients, non-profit organizations emphasized the need for control in salaries. Yet, hospital procurement of equipment and supplies was completed at market

rates. Chafe (1972) concluded that the economic conditions of women in America reflected much the same inequities. Female workers sought jobs, not careers; so even after the Second World War when the number of women in the workforce increased, economic inequality persisted. Furthermore, Chafe stated that "economic equality could be achieved only through a substantial revision of social values and a lasting modification in the nature of male-female relationships" (p. 172).

According to Alexander (1978), the economic exploitation of nurses employed in the hospital setting has been a big issue. Currently, due to state and federal laws governing third party payments, nurses are restricted as to their options concerning employment. The majority of nurses must be employed by someone else, placing them in a subservient situation both economically and professionally. Archer and Goehner (1982) noted that although major steps have been instituted to address the economic security of nurses, the majority of nurses still do not recognize the need to become involved with economic issues. They added that as long as somebody else controls the purse strings without adequate input from the profession, nurses will be economically powerless. In order for those social values to change, women must band together for that common cause.

And the first step toward economic equality seems to be that of learning to work together productively toward a common goal and to participate in the political system.

Mullane (1976) defined politics as the art and science of influencing policy. However, without cohesiveness, groups usually cannot influence policy. Chafe (1972) stressed that women entered the political arena without a cohesive and committed group. This lack of cohesion was manifested after the right to vote was won in 1920, a situation in which women showed no evidence of collective self-consciousness. According to Chafe (1972), the basic problem was the failure of the suffrage movement to change the special status of women in relation to the society as a whole. Females as a group still conformed to the role of the helpmate rather than asserting their independence. As a result, discrimination against women became deeply rooted in the structure of society.

The political movement of nurses and females in general followed the pathway of their social, economic and historical development. According to Millett (1969), the primary focus of the woman's suffrage movement was formal politics affecting equality of education, law, and pay. She further noted that the battle to win the right to vote was so extensive and exhaustive that it resulted in the collapse of the

feminist movement. As indicated by Archer and Goehner (1982), the "reasons for nurses' low political participation are related to an overriding deficit: nurses are generally not taught or encouraged to become politically active" (p. 6).

Etzioni (1969) stressed that nurses have achieved only limited input into the establishment of institutional policies concerning their own working conditions, hours, or salary. Hospital administrators and physicians have been identified as the policy and decision makers. However, recently there have been developments regarding political action committees and utilization of the collective bargaining process. These activities are an indication of awareness on the part of some nurses that being involved is very important for the growth of the individual both professionally and personally. However, as Ashley (1975b) indicated, the majority of nurses do not recognize the importance of influencing policies or the effect of organizational factors on their ability to do so. They fail to recognize that they must be knowledgeable about the issue, capable of composing themselves effectively, and show willingness to exercise the right to an equal voice in the health care system.

Organizational Factors Related to Powerlessness

According to Taglieri (1973), an "organization is two or more persons interacting within a recognized power relationship for some common purpose" (p. 3). He stated that an organization must have three basic elements: (1) a leader, (2) a follower, and (3) a job to be done. Each of these elements interacts in the organizational environment in a way "that tends to integrate or disintegrate the organization" (p. 4). He concluded that when the elements are integrated, harmony exists and the job is done efficiently and effectively. However, the admixture of these elements can lead to disintegration of the whole organization.

According to MacFarland and Shiflet (1979), a hospital is a complex system which utilizes organizational structure. Organizational managers provide for nurses job opportunities that are structured with clientele, goals, planning, and resources. Stuart (1981) noted that 65% of nurses work in hospital settings and MacFarland and Shiflet (1979) stated that they compose approximately 60% of the personnel employed by a hospital.

Organizational hierarchy. According to Ashley (1976a), traditionally and currently, nurses assume the responsibility

for the care of the patients in every health care institution. However, in reviewing the graphic organizational structure of an institution, the reader will see that nurses are almost always near the bottom of the chain of command. Ashley noted that administrators are on the top of the chain of command and on the same level are the physicians, who are considered as privileged entrepreneurs. According to Alexander (1978), within the traditional bureaucratic hospital environment, nurses are required to give up the right to make decisions that affect their patients' nursing care. He added that they follow the old traditional approach in which they are encouraged to be subservient to the physicians, hospital administrators, and their nursing colleagues whom they regard as authority. As a result, decisions are made for the nurses by the people above them.

Zungolo (1968) stressed that staff nurses within the hospital setting are thrown into a powerless role, partially due to violation of the unity of command principle. As a management principle, unity of command prescribes that a worker should have only one boss. But, in a hospital setting, Zungolo noted that nurses relate to two lines of authority, that of the hospital administrator and that of the physician. In this two-part system, according to

Mundinger (1980), administrators direct the nursing service to patients and the physicians direct the daily medical activities of nursing personnel. However, Ashley (1976a) indicated that "nursing care goes on without either the consultation or the presence of the physician" (p. 129). Furthermore, Ashley (1973) viewed hospitals as similar to the industrial concerns in which the working group (nurses) is the largest source of production, and in which head nurses, managers, and administrators are responsible for the maximum and efficient productivity and performance of the group.

As Mundinger (1980) noted, the two-boss system leads to violation of the unity of command principle, resulting in role ambiguity and conflict for the nurse. The physician gives orders and the nurse is required to follow them; failure to follow and carry out the physician's orders can lead to financial and professional liability. The hospital administrators and managers are responsible for hiring and providing salary and benefits for the nurses. They set the policies and make decisions for the nurses to follow. Mundinger added that in the event that a conflict develops involving the nurse, the physician, and the administrator, the nurse will usually lose.

According to Hendricks (1982), there are three principle actors in the hospital's top management: the

hospital administrator, the physician, and the nurse. He further stated that the relationships that exist between these actors are based upon "the relative power and status of each position as well as the professional and personal value systems of the three individuals involved" (p. 23). She noted that, due to multiple social, cultural, sexual, and traditional reasons, nurses hold the weakest position in this triad. Stevens (1983) stressed that "this brutal fact renders the nurse powerless to improve many conditions of employment" (p. 138). Finally, nurses are also controlled by their own colleagues, for example, nursing supervisors and head nurses. Ashley (1973) proposed that supervisors tend to identify with the power of administration and medicine instead of with their own profession.

No studies were found in which nurses working in auxiliary and nursing service departments were compared. The lack of information in this area led the investigator to consider the studies in which nurses working in specialty and non-specialty units were assessed. Lewandowski and Kramer (1980) compared specialty (intensive care) and non-specialty nursing units. They cited such variables as role conception, role deprivation, professional bureaucracy, bi-cultural role behavior, self-esteem, empathy, self-actualization, and change activity as variables. They

claimed that specialty unit nurses possess a specialized body of knowledge and have often taken additional and specialized training to attain detailed and scientific knowledge. They indicated that these nurses were acknowledged as having specialized skills, competence, and as belonging to a specific professional group. These nurses, therefore, have a greater degree of autonomy and independence than those in non-specialty areas. Internal standards, coordination, and peer control are generally operative in specialty units to a greater extent than in non-specialty settings since nurses in these units are often left to coordinate their own activities. Furthermore, they contended that the nursing supervisors are less likely to exert control over the nurses who work in specialty areas because the supervisors are usually less knowledgeable of what is going on than the nurse who works in that unit.

Although no literature could be found in which the role of the nurse in auxiliary units was presented or analyzed, it is possible that nurses in these settings also experience greater freedom and autonomy in practice than nurses on regular units. Auxiliary units also provide for complexity of tasks, such as providing direct patient care to those who undergo diagnostic and therapeutic procedures, they possess a specialized body of knowledge, undergo additional training,

and they belong to a specific professional group. Auxiliary nurses must keep abreast of new technology and equipment. They serve as educators not only to the patient and family, but also to the allied health professionals with whom they work. The circumstances in which the role is enacted permit nurses working in these areas to achieve a higher degree of freedom and self-control than those on general nursing units. Due to the nature and directness of administrative contact in the auxiliary or specialty units, nurses working in these areas may experience greater autonomy in practice. A patient who is undergoing a diagnostic and/or therapeutic procedure, connected to a monitoring device or to a dialysis machine, experiencing a physiological and/or psychological crisis state, or immobilized is more dependent upon the health care personnel than an ambulating, decision-making patient often found in the general units. Because of the greater geographic proximity, there may also be a greater group-cohesiveness and group-shared norms. On the other hand, nurses in general nursing areas who usually work in greater isolation, and in the face of a less critical patient population, may find the team effort to be less obvious.

Gender. The issue of gender is another inherent problem that nurses must face in the organizational structure

of the hospital. Lieb (1978) noted that in the health care industry, the female workers are located at the base of the pyramid, while the predominantly male physician group is situated on the top of the pyramid, giving them control of all resources, including materials and manpower. As a result, the physicians achieve their goals and maintain their power.

Investigators such as Cleland (1971), Ehrenreich and English (1973), Kushner (1973), Ashley (1973, 1976a, 1976b, 1980), Wolf (1977), Lieb (1978), Lovell (1981), Archer and Goehner (1982), and Stevens (1983) have agreed that the main reason underlying the nurses' sense of lack of control is that the majority of nurses are female in a male dominated health care system. According to Kushner (1973), nurses, feminists and behavioral scientists recognize the traditional status of women as secondary to men. The physicians are males who take charge, while the nurses are females who serve and provide care to the patient.

According to Ehrenreich and English (1973), the nursing profession is comprised of a "silent passive majority" (p. 3). This silence, according to Lovell (1981), has historical basis equivalent to that of women in general and it is perpetuated by nurses. Lovell (1981) noted that by virtue of this silence, nurses beg to be controlled, while

the male-dominated medical profession happily complies with their request.

Bloch (1978) stated that "powerlessness is the most common form of alienation occurring when nurses experience a discrepancy between the power they think they have and what they believe they should have" (p. 123). Zungolo (1968) noted that most of the problems facing nurses in the hospital setting are similar to those of workers in the industrial society. Bloch (1978) and Pearlin (1962) stated similar views. They indicated that nurses are likely to be a target for alienation as they are unable to fulfill the expectations of their role as they perceive them.

Role conflict. The primary role of nurses is to render quality nursing care. However, as Zungolo (1968) indicated, they are often expected to perform many non-nursing functions within the hospital environment. Most of the policies and decisions related to their work are made for them. They have little input on these matters; if they are asked for their input, it is usually in a limited capacity. Nurses may portray themselves as autonomous professionals, but physicians view them as dependents. According to Zungolo, all of these factors add to nurses' feelings of lack of control over the work situation. Furthermore, Stuart (1981) noted that regulations related to nursing roles are often

developed by members of the authority structure without input and consultation from the nurses who occupy these roles. Stuart (1981) indicated that this situation contributes to the high turnover rate of nurses in the work force.

According to Cowden (1978), the nurses' role conflict was brought about by the evolution of nursing from a Christian vocation focused on service and altruism to the current day profession which is focused on fulfillment of personal rewards as well as service goals. Furthermore, he stated that the nursing role had shifted away from a direct, personal caring for the patient, to a mechanical, technical, and impersonal approach.

Corwin (1961) indicated that there are three conflicting roles for nursing: (1) the professional role which focuses on professional nursing ethics involving higher quality care and maximum nursing expertise; (2) the bureaucratic role which focuses on primary allegiance to the hospital administration; and (3) the service role which involved personal and sentimental devotion to the patient. Utilizing these ideas, Corwin (1961) studied 201 staff nurses, 23 head nurses, and 71 junior and senior student nurses with diploma or degree training. The participants were randomly selected from seven hospitals and four nursing schools located in a midwestern metropolis. This study was

conducted to assess the bureaucratic, professional, and service role conceptions. His findings indicated that baccalaureate degree nurses with a higher professional self-concept were more threatened by the requirements of a bureaucratic hospital role than the diploma nurses. He concluded that such findings seemed to indicate that the presence of three models for practice promoted division of loyalties to the point of being incompatible in some cases.

Kramer and Baker (1971) stated that nurses were socialized into a professional role in school, but practiced within a bureaucratic setting which requires significant modification of that role after graduation. They termed this conflict as "reality shock," which seemed to occur more readily for the baccalaureate nurse than for the diploma nurse. In their six year study involving semi-structured interviews of 220 staff nurses with baccalaureate degrees from different hospitals in one city, Kramer and Baker (1971) found that reality shock existed due to conflicting nurses' roles. Furthermore, they found that this reality shock resulted in a drop-out rate from the nursing profession of 28.9%, strictly due to job dissatisfaction.

Several investigators in assessing reasons for dissatisfaction and turnover among staff nurses found that nurses cited factors related to conflicting perceptions of

their role. In 1978, Godfrey published the results of a survey by Nursing '78 on job satisfaction. Nearly 17,000 nurses responded indicating that the leading causes of job dissatisfaction include unsafe practices prescribed by the administration, poor leadership, and breakdown in communication.

Based on a review of literature, Wolf (1981) identified problems with the work environment such as too much work or inadequately prepared staff, inadequate supervision and coordination, and administrative policies and philosophy as the major factors related to job dissatisfaction. In addition, Seybolt and Walker (1980) indicated that dissatisfaction was responsible for absenteeism, decreased commitment and an increased incidence of mental and physical disorders.

In 1980, Wandelt, Hales, Merwin, Olsson, Pierce, and Widdowson stated that there are three basic conditions inherent in the hospital setting which they gave as reasons for nurses not working: (1) lack of administrative support; (2) lack of autonomy; and (3) lack of opportunity to update knowledge and skills. Brief (1976) echoed similar views when he suggested that there are four factors that will cause nurses' dissatisfaction with their jobs. They were: (1) lack of a sense of autonomy; (2) lack of a sense of identification with their tasks; (3) lack of a challenge to

develop new skills; and (4) lack of adequate feedback about their performance. Furthermore, Brief (1981) stated that the lack of commitment in their work role can be viewed as the factor that causes nurses to make the decision to leave the nursing profession.

Wandelt, Pierce and Widdowson (1981) conducted a survey of 3,500 nurses in the state of Texas regarding factors related to dissatisfaction. A rank order of the conditions which the nurses noted as most responsible for job dissatisfaction in nursing were:

1. Availability of adequate salaries
2. The amount of paper work
3. Support given by the administration of the facility
4. Opportunity for continuing education
5. Adequacy of laws regulating the practice of nursing
6. Support given by nursing administration
7. Availability of acceptable child care facilites
8. Availability of inservice education
9. Availability of fringe benefits
10. Competence of non-registered nursing staff (p. 77)

Although these studies do not directly address alienation in the form of powerlessness, they do indeed show that perceived lack of control within the organization of the hospital is viewed by nurses as a factor in the decision to leave the nursing profession.

Personal and Professional Factors

The role of the nurses in the health care profession is to provide quality patient care. The quality of patient

care is the reflection of the personal and professional acceptance of the nurse of their role as a health care provider. According to Ashley (1973), nursing power is a productive force that can be used to single handedly maintain the health care system today. Nurses are seen in almost all areas of health care including the physicians' offices, hospital settings, and school systems. They serve as health care providers, counselors, educators, managers, and so forth. To summarize, Ashley (1976a) noted that traditionally and currently, the nurses "assume responsibility for most of the care given to most people in almost every health care facility in the country" (p. 124).

Nurses are armed with personal and professional power to influence the needed changes in nursing as a profession. According to Stevens (1983), the sources of nurses' power include the personal and professional bases. The personal bases of power relate to the nurse's "ability to project a positive image of self-confidence, self-esteem, and competency" (p. 17). Stevens indicated that, while the professional power bases are tied to membership in professional organizations and associations, these power sources are positive forces for the nurse to utilize as instruments to "reform the health care system and strengthen the nursing profession" (p. 20).

On the other hand, these sources of power could contribute to nursing powerlessness if not utilized properly. Chaisson (1979) claimed that there is no intention of keeping the nurses powerless, but nurses themselves are the ones who compromise their own power. According to Ashley (1973, 1980), Diers (1978), and Halsey (1980), nursing power is hindered due to women's prejudices against each other, especially in their competitive effort to obtain male approval.

Ashley (1980) claimed that the close alliance to the male dominated profession of medicine has reinforced the nurses' lack of power. This close relationship results in difficulty in distinguishing between the behaviors of the two professions, not only by the lay person, but also by the nurses themselves. Fagin (1978) viewed nursing powerlessness as due to the nurses' refusal to accept responsibility for independent nursing decisions. She stated that nurses seek out decision making within medicine's realm, rather than within their own.

According to Stevens (1983), nurses are endowed with two crucial assets: (1) decisions and time, and (2) decision making and time management skills. These two assets can improve and increase the personal effectiveness of a nurse. However, she indicated that presently "the nurse's

self-image is wrought with feelings of powerlessness and decreased personal confidence, which preclude using the power that she may already possess" (p. 19).

Nursing education is another issue related to the powerlessness of nurses. According to Fagin (1978), the nursing educational system is based on an "archaic" program. Her concern is that this preparation is not adequate enough to provide nurses with personal and professional power. According to Stevens (1983), during the evolution of nursing education, there were rapid changes that took place in the educational process. She stated that "nurses prepared at various entry levels, associate degree, diploma, and bachelor's degree are unclear about similarities and differences in their competence" (p. 277). The negative impact of this situation is manifested by "hostility toward other kinds of nursing programs and their graduates" (p. 43). In addition, Stevens noted that:

> nursing is a profession composed largely of women with a variety of patterns of basic and post-basic education, lack of clarity of levels of practice based on that education, and an ideological split between those who educate nurses and those who employ them. (p. 45)

She further stated that nurses project multiple images instead of one, and most of the time these "images are contradictory rather than complimentary" (p. 44). Nurses fail to capitalize on their number to portray a positive image

of being knowledgeable and that their contribution in the health care system is unique and irreplaceable. Instead, nurses project fragmentation, uncertainty and powerlessness. As a result, nurses fail to develop the needed autonomy, prestige and power in the nursing profession.

Currently, there are two major professional nursing organizations, the American Nurses' Association (ANA) and the National League for Nursing (NLN). Stevens (1983) stated that nurses seek membership in nursing organizations in order to meet with other nurses who share common interests to discuss issues related to their practice areas. However, when the role and functions of ANA and NLN are examined, duplication of efforts and fragmentation of responsibilities are apparent. This fragmentation creates an erosion and weakening of the needed power base in nursing, and the nurses themselves feel powerless to influence changes in the health care delivery system.

Nursing leadership is another element related to the feelings of powerlessness among nurses. According to Hassenplug (1976), all nursing administrators have power to influence the nursing practice. This power is achieved by the nursing administrators by virtue of their knowledge and nursing competency, the position they are in, the way they portray themselves, and the degree to which they make

themselves visible. She further stated that these nursing leaders can spread their power at the policy level by working closely with their nursing colleagues, by sharing their authority with them, and by delegating responsibility for the delivery of quality nursing care to the staff nurses. However, according to Ashley (1973), nurses in leadership positions have problems communicating with their nursing colleagues and in developing inter-personal relationships. In addition, she claimed that these leaders have the tendency to identify with the powers of administration and medicine instead of with nursing and their nursing colleagues.

According to Halsey (1980), nurses in management positions tend to manifest the Queen Bee syndrome. As Queen Bees, the nurses in leadership positions have the following characteristics: (1) the nurses identify with men in the work setting instead of their peers; (2) the nurses manifest status quo to avoid conflict; (3) the nurses prevent competition by other nurses; (4) the nurses project anti-feminist standards upon other females; (5) when confronted with problems, the nurse-leaders use individual strategies instead of group participation; (6) the nurse-leaders consciously believe that they are rewarded for their talents; and (7) when faced with problems related to nursing, the

nurse-leaders view these problems as problems with interpersonal skills. Chaisson (1979) noted that these nurses in leadership positions isolate themselves from their nursing colleagues and often do not identify with their primary profession. This behavior reinforces the "negative image of nursing at the very time in their career when they are best able to advertise a prime example of what nurses can be and do" (p. 5). Ashley (1973) and Halsey (1980) reiterated that these nursing leaders tend to seek out and identify with male dominated groups instead of with the nursing colleagues whom they represent. Nurses are thus faced with multiple personal and professional elements that foster their feelings of powerlessness.

Public Image

The patient or client who receives nursing care also forms a view of the nurse's role. This public image of the nurse can enhance feelings of powerlessness in nurses in the work environment. According to Fagin (1978), society does not value the nurses' ability to provide nursing care. Ashley (1973) added that society does not recognize the difference between medical and nursing care. She contended that "physicians have encouraged the public to believe that the separate and distinct contributions of nursing care can be attributed to medical skill" (p. 641). Furthermore,

according to Hassenplug (1976), the general public does not see the professional nurse as an independent, accountable practitioner, but rather as a helper or assistant to physicians. Stevens (1983) echoed a similar view. She stated that nursing as a profession portrays an image of being in disarray. As a result, nurses are having difficulty in coping with the changing health care environment and the role of nursing within it.

The feeling of powerlessness is a result of multiple factors facing the nursing profession. As an end result, nurses are inhibited in achieving their nursing goals. According to Millar (1981) and Kramer (1974), these feelings will eventually paralyze the profession and result in nurses totally leaving the nursing profession.

Summary

Perceived feelings of powerlessness can influence individuals' attitudes toward their jobs. Attributes that influence the perceived feelings of power are the same ones that could lead to the perceived feelings of powerlessness. As nurses, individuals must use power in order to achieve their full professional potential and to maximize their contribution to health care and society in general. But, before nurses can attain such power, they must first understand the attributes that contribute to their feelings of

power or powerlessness, the nature of power, and the available sources of power.

The concept of powerlessness was developed by Seeman (1959). It is a variant of alienation which is subjective in nature. As a psychological-sociological dimension of alienation, powerlessness was developed based on sociological theories and social learning theory.

Researchers have shown that the individuals' perceived feelings of powerlessness and/or alienation toward their work may be due to multiple negative attributes. The feelings of loss of control exist in diversified work settings ranging from unskilled manual labor to professional practice. Professionals are particularly inclined to feel alienated or powerless when they are employed by the organizations which hinder and interfere with their professional goals and professional growth.

The nurses who work in the hospital setting are more likely to perceive the feelings of powerlessness in the work environment. They are subjected to multiple factors such as the organizational structure, professional and personal factors, and their public image. In the hospital organizational structure, nurses are subjected to the hierarchy of the institution and are under the twofold chain of command. They are members of a predominantly female profession,

within a male dominated work setting. Often their own nursing colleague superiors identify with the male hierarchy.

The economic, social, and political histories of nursing and women in general share an interesting source for substantiating the perceived feelings of powerlessness in the nursing profession. Problems such as education, lack of cohesiveness, leadership, and public image/opinion currently confront professional nurses. These factors tend to foster powerlessness of nurses in the work setting. Confronted by these issues, the staff nurse is more likely to feel powerless. She experiences powerlessness in the sense that she feels that her own behaviors cannot determine the occurrence of outcomes or reinforcements she seeks in the practice-oriented environment. In the practice-oriented environment, the staff nurse seeks for the attainment and maintenance of quality nursing care for her patients. In addition, she seeks personal and professional growth and advancement while staying in the profession instead of totally leaving the nursing profession.

CHAPTER 3

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

In this chapter, the methodology used in the study is described. It specifically includes a description of the setting, population and sample, protection of human subjects, the instrument used, and the procedure for the collection and treatment of data.

Setting

The sample for the study was selected from nurses employed in a large metropolitan private teaching institution located in a southwestern medical center. There are approximately 1,851 nurses employed in this hospital. Group 1 subjects were staff nurses working in auxiliary units which were not under the auspices of the nursing service department. These auxiliary units are located in different buildings of the hospital complex. Each member of this group reports administratively to the Nursing Supervisor or Director of the department who in turn is directly under a Vice President of the Diagnostic and Therapeutic Services. Group 2 subjects were staff nurses in general non-specialty nursing units. These units are located in the Main Building of the hospital complex. Each staff nurse reports directly

to the Head Nurse of the unit, who in turn reports to the Clinical Area Manager, Director of Nursing or Assistant Vice President of the nursing service department.

A descriptive, nonexperimental survey was conducted in the work areas of those who agreed to participate. The work areas of Group 1 subjects included: Circulatory Dynamics, Hemodialysis, Hypertension, Peripheral Vascular, and Radiology nursing units. The work areas of Group 2 nurses were the medical and surgical general care units.

Population and Sample

The population consisted of full-time female registered nurses with a minimum of 12 months tenure in their present area of employment. They were employed in a staff position in either an auxiliary services unit or a nursing service unit. Questionnaires were delivered to 150 nurses who were conveniently selected from the master list obtained from the Human Resources Department of the selected institution. The sample was comprised of 109 nurses who met the above criteria, agreed to participate, and who correctly completed the questionnaires.

The rationale behind the criteria for inclusion in the sampling was as follows. Only nurses with at least 12 months of employment were sampled in order to permit a time period adequate to develop attitudes about power/

powerlessness and the knowledge required to function within the unit. Nurses working part time were excluded since they might not work for a sufficient time to develop realistic attitudes. Only female nurses were included to control for the extraneous variable of sex. Nurses who were holding positions above the staff level were excluded since feelings of control, accompanied by additional responsibility and status, might alter the perception of powerlessness.

Protection of Human Subjects

Permission to conduct the study was obtained from the Human Subjects Review Committees at Texas Woman's University, at the selected agency, and at the affiliated medical school. The subjects' rights were protected in the following manner:

1. The subjects' participation was voluntary with the understanding that their participation would in no way affect their treatment by the employing institution.
2. The subjects were informed that they could withdraw at any time. The consent to participate in the study was implied by the return of the completed questionnaire.
3. No names were placed on the questionnaires; however, code numbers were utilized for identification purposes in the follow-up of non-respondents.

4. A single master code list with the participants' names was in the possession of the investigator only, kept in a locked file, and destroyed upon completion of the study.
5. The names of the participants and the name of the studied institution were not mentioned in the study.

Instrument

Guilbert's Health Care Work Powerlessness Scale (Instruments, 1979) was used to measure the dependent variable. This instrument was developed to measure the feelings of powerlessness of workers in health care settings. The variable of powerlessness was conceptually defined as "the extent to which the health worker believes she has little or no control over events relevant to her work" (Instruments, 1979, p. 37). This instrument was developed specifically for use with health care workers.

Guilbert's Health Care Work Powerlessness Scale (Instruments, 1979) consists of 14 paired statements. One statement of each pair represents powerlessness, while the other represents lack of powerlessness. The scale requires a forced-choice response, wherein the participant is asked to endorse one of the pair of statements (see Appendix B). Each item representing powerlessness is given a score of one, and each item representing lack of powerlessness is given a

score of zero. Possible scores are from 0 to 14, with 0 representing the absence of powerlessness and 14 representing a high level of powerlessness. The dependent variable was measured at the ordinal level.

Guilbert (Instruments, 1979) developed the work powerlessness scale utilizing a design similar to that used by Seeman (1963) in his studies of alienation. The instrument is divided into 14 items, and out of 14, 9 items were reviewed by Seeman for content validity. Five new items were added and submitted to a three-member panel of judges for review. As of this date, no other types of validity have been established. The instrument was administered to two small groups. The first group had six participants and yielded a .72 split-half reliability coefficient. The second group had 15 participants and yielded a .81 reliability coefficient. Both groups were extremely heterogeneous in educational backgrounds. According to Guilbert (long distance telephone conversation with the author in April, 1984), the most recent reliability coefficient was .75 (Cronbach's alpha), when the instrument was administered to a group of 277 nurse administrators. The instrument was also administered to 128 registered nurses and yielded a .769 split-half reliability coefficient. The determination of a reliability coefficient for the study group was

achieved utilizing the Cronbach's alpha technique. Permission for using the Health Care Work Powerlessness Scale was obtained from Guilbert (see Appendix C).

The personal data sheet (see Appendix B) was developed to identify the work areas and to obtain information on the extraneous variables of age, education, marital status, race, shift rotation, and tenure. It also included work status, tenure at current job and levels of nursing education, in order to ensure that the previously cited criteria for selection were maintained.

The extraneous variables which were included in this study were identified from the literature through studies on alienation, internal versus external control, and powerlessness. In reviewing the studies on powerlessness, Lystad (1972) found a realtionship between powerlessness and age, race, sex, and religion. Pearlin (1973) identified shift rotation among nursing personnel as having a relationship to the perception of powerlessness. Seeman (1963, 1966, 1967b) established a relationship between knowledge of control-relevant information and powerlessness. This finding also supports consideration of tenure and education level in the study. In addition, Frerichs (1973) found that marital status has an effect on or is related to feelings of internal control.

Data Collection

To maintain the consistency in conducting the research study, the instruments were hand carried by the investigator to the clinical areas and distributed to the subjects. The questionnaire was accompanied by a cover sheet with directions for completing the powerlessness scale and the Personal Data Sheet. Both the personal data and the instrument sheets were pre-coded and categorized to simplify the data analysis. Each questionnaire had an identification number. Subjects were requested to return the completed questionnaires within two weeks. To maintain anonymity, a box was provided on each participating unit into which the participant dropped the completed questionnaires. The contents of these boxes were collected by the investigator every 24 hours. All questionnaires were reviewed for accuracy and completeness.

Treatment of Data

Frequencies were used to describe the sample in terms of age, education, marital status, race, tenure, shift rotation, and work setting. Since data obtained from the questionnaire was considered to be ordinal, nonparametric measures were used to analyze the data. The nonparametric Mann-Whitney U Test and Kruskal-Wallis Test were used to measure the differences among groups based on the dependent

variable and the demographic factors. The Spearman correlation coefficient was used to measure the relationship between continuous demographic factors and scores on the questionnaire. Cronbach's alpha was used to assess the reliability of the instrument.

Summary

A nonexperimental, descriptive cross-sectional survey was conducted to determine if there was a difference in the feelings of powerlessness between staff nurses employed in the auxiliary and nursing service departments. The population consisted of full-time, female, registered nurses, with a minimum of 12 months tenure who were employed in a large metropolitan private teaching hospital. Questionnaires were hand delivered to 150 nurses. The sample was comprised of 109 participants. Permission to conduct the study was obtained from the Human Subjects Review Committee at Texas Woman's University and the selected institution. Provisions were made to protect the rights of the participants. The Guilbert Health Care Work Powerlessness Scale, together with the demographic data sheet were administered. The data were analyzed using frequency distributions, medians, a Kruskal-Wallis, a Mann-Whitney *U*, and Spearman correlation coefficients.

CHAPTER 4

ANALYSIS OF DATA

A nonexperimental, descriptive study was conducted to determine if there was a difference in the feelings of powerlessness among staff nurses who worked in auxiliary and nursing service departments. In this chapter, the results of the data analysis are described. The first part includes the description of the sample; the second part consists of the research question under investigation and the effect of the identified demographic variables on the relationships of the independent and dependent variables.

Description of Sample

The sample for this study consisted of 109 nurses employed in staff positions. The subjects comprised a convenience sample of staff nurses who were employed in the auxiliary and nursing service departments. Thirty-four (31.2%) auxiliary nurses (Group 1) returned their completed questionnaires. A total of 75 (68.8%) nurses (Group 2) employed in the nursing service department returned their completed questionnaires. The specified work settings for each group of nurses are shown in Table 1.

Table 1

Frequency Distribution of Work Areas of 34 Staff Nurses Employed in the Auxiliary Nursing Department and 75 Staff Nurses Employed in the Nursing Service Department

Work Areas	Number	Percent
Auxiliary Units		
Circulatory Dynamics	11	32
Hemodialysis	11	32
Hypertension	3	9
Peripheral Vascular	3	9
Radiology	6	18
Total	34	100
Nursing Units		
General Surgery	36	48
General Medical	39	52
Total	75	100

The completed questionnaire and personal data sheet of each subject were collected during the day shift on 15 consecutive days in the month of November, 1984. Data for each of the seven demographic variables are discussed below.

Age

Ages of the participants were 23 to 64 years (Table 2). The largest concentration of respondents was between 30-39 years of age. The mean age was 35 years, the range was 41 years, and the standard deviation was 7.594.

Table 2

Description of the Sample According to Age, Ethnic Origin, and Marital Status

Variables	Nurses					
	Auxiliary		Nursing Service		Total	
	n	%	n	%	n	%
Age in Years						
20-29	5	14.7	19	25.3	24	22.0
30-39	23	67.6	41	54.7	64	58.7
40-49	6	17.7	6	8.0	12	11.0
50-59	0	0.0	8	10.7	8	7.4
60-69	0	0.0	1	1.3	1	.9
Total	34	100.0	75	100.0	109	100.0
Ethnic Origin						
White	26	76.5	37	49.3	63	57.8
Black	4	11.8	6	8.0	10	9.2
Brown	4	11.8	32	42.7	36	33.0
Total	34	100.0	75	100.0	109	100.0
Marital Status						
Never Married	8	23.5	18	24.0	26	23.9
Married	18	53.0	51	68.0	69	63.3
Divorced	8	23.5	6	8.0	14	12.8
Total	34	100.0	75	100.0	109	100.0

Ethnic Origin

The majority of the respondents were white (63; 57.8%) (Table 2). Thirty-six subjects (33%) classified themselves as brown, while 10 (9.2%) indicated that they were black.

Marital Status

The majority (69; 63.3%) of the respondents were married (Table 2). Twenty-six (23.9%) subjects indicated that they had never married, while 14 (12.8%) classified themselves as divorced.

Education in Nursing

Of the respondents, 45 (49%) indicated that they had obtained a bachelor of science in nursing (BSN)(Table 3). The rest of the respondents indicated either a diploma or associate degree in nursing, 42 (38.5%) and 18 (16.5%), respectively. It is of interest to note that 35 (46.7%) of the respondents from Group 2 and 14 (41.2%) from Group 1 had acquired a BSN degree.

Education in Other Areas

Most of the subjects (80; 73.4%) reported not receiving education outside of nursing (Table 3). It is of interest to note that 17 (15.6%) subjects received a bachelor of arts or a bachelor of science degree in an area other than nursing.

Shift

The majority of the respondents (61; 56%) worked during the day time (Table 4). Twenty-seven (24.8%) of the

Table 3

Description of the Sample According to Education in Nursing and Education in Other Areas

Variables	Nurses					
	Auxiliary		Nursing Service		Total	
	n	%	n	%	n	%
Nursing Education						
Diploma	15	44.1	27	36.0	42	38.5
Associate	5	14.7	13	17.3	18	16.5
BSN	14	41.2	35	46.7	49	45.0
Total	34	100.0	75	100.0	109	100.0
Other Education						
None	25	73.4	55	73.3	80	73.4
Associate	3	8.9	8	10.7	11	10.1
BA/BS	6	17.7	11	14.7	17	15.6
Master's degree	0	0.0	1	1.3	1	.9
Total	34	100.0	75	100.0	109	100.0

respondents worked during the evening shift, and 16 (14.6%) worked at night.

Tenure

Tenure of the respondents was 1 to 24 years (Table 4). The largest number (89; 81.7%) of respondents had worked from 1 to 5 years. The mean was 4.156, the range was 23, and the standard deviation was 4.051.

Table 4

Description of the Sample According to Shift Worked and Tenure in the Employing Institution

Variables	Nurses					
	Auxiliary		Nursing Service		Total	
	n	%	n	%	n	%
Shift						
Day	29	85.3	32	42.7	61	56.0
Evening	4	11.8	23	30.7	27	24.8
Night	0	0.0	16	21.2	16	14.6
Variable	1	2.9	4	5.4	5	4.6
Total	34	100.0	74	100.0	109	100.0
Tenure in Years						
1- 5	26	76.4	63	84.0	89	81.7
6-10	5	14.7	6	8.0	11	10.1
11-15	3	8.9	4	5.4	7	6.4
16-20	0	0.0	1	1.3	1	.9
21-25	0	0.0	1	1.3	1	.9
Total	34	100.0	75	100.0	109	100.0

Findings

The research question was: Is there a difference in the feelings of powerlessness among staff nurses employed in auxiliary departments and staff nurses employed in nursing service departments? The responses to the Guilbert Health Care Work Powerlessness Scale were scored in the following manner: feelings of powerlessness or lack of control = 1;

feelings of lack of powerlessness or having control = 0. The highest possible total score on this questionnaire was 14, which denotes greater feelings of powerlessness. The scores of respondents varied from 1 to 13 (Table 5).

Table 5

Summary of the Scores of Auxiliary and Nursing Service Staff Nurses on the Guilbert Health Care Work Powerlessness Scale

Scores	Nurses					
	Auxiliary		Nursing Service		Total	
	n	%	n	%	n	%
1	4	11.8	10	13.3	14	12.8
2	5	14.7	9	12.0	14	12.8
3	4	11.8	6	8.0	10	9.2
4	5	14.7	15	20.0	20	18.3
5	2	5.9	5	6.7	7	6.4
6	4	11.8	8	10.7	12	11.0
7	1	2.9	6	8.0	7	6.4
8	0	0.0	3	4.0	3	2.8
9	3	8.8	4	5.3	7	6.4
10	2	5.9	4	5.3	6	5.5
11	1	2.9	2	2.7	3	2.8
12	2	5.9	2	2.7	4	3.7
13	1	2.9	1	1.3	2	1.9
14	0	0.0	0	0.0	0	0.0
Total	34	100.0	75	100.0	109	100.0

An item-by-item summary of the auxiliary and the nursing service department staff nurses' scores on the Guilbert Health Care Work Powerlessness Scale was prepared (Table 6). The first item was the individual's ability to influence the organizational working conditions. Twenty-three (67.6%) of the auxiliary department nurses specified a lack of powerlessness, while 11 (32.2%) indicated feelings of powerlessness. Fifty-eight (77.3%) of the nursing service department nurses indicated lack of powerlessness, while 17 (22.7%) indicated feeling of powerlessness. In response to the first item, a majority (81; 74.3%) of the total sample of staff nurses indicated a lack of powerlessness in influencing the organizational working conditions.

The second item was the individual's influence on the type of treatment program a patient will receive. Twenty-seven (79.4%) of the auxiliary department nurses designated a lack of powerlessness, and 7 (20.6%) indicated feelings of powerlessness. Fifty-four (72%) of the nursing service department staff nurses specified a lack of powerlessness, and 21 (28%) indicated feelings of powerlessness. Therefore, in response to item 2, a majority (81; 74.3%) of this sample of staff nurses indicated a lack of powerlessness in influencing the type of treatment program a patient had received.

Table 6

Summary of Responses of the Auxiliary and Nursing Service Staff Nurses to Each Question on the Guilbert Health Care Work Powerlessness Scale

Question	Auxiliary Nurses' Scores				Nursing Service Nurses' Scores				Total Nurses' Scores			
	0[a]		+1[b]		0[a]		+1[b]		0[a]		+1[b]	
	n	%	n	%	n	%	n	%	n	%	n	%
1	23	67.6	11	32.2	58	77.3	17	22.7	81	74.3	28	25.7
2	27	79.4	7	20.6	54	72.0	21	28.0	81	74.3	28	25.7
3	17	50.0	17	50.0	45	60.0	30	40.0	62	56.9	47	43.1
4	26	76.5	8	23.5	57	76.0	18	24.0	83	76.1	26	23.9
5	28	82.4	6	17.6	67	89.3	8	10.7	95	87.2	14	12.8
6	20	58.8	14	41.2	46	61.3	29	38.7	66	60.6	43	39.4
7	19	55.9	15	44.1	41	54.7	34	45.3	60	55.0	49	45.0
8	27	79.4	7	20.6	63	84.0	12	16.0	90	82.6	19	17.4
9	22	64.7	12	35.3	47	62.7	28	37.3	69	63.3	40	36.7
10	17	50.0	17	50.0	51	68.0	24	32.0	68	62.4	41	37.6
11	12	35.3	22	64.7	21	28.0	54	72.0	33	30.3	76	69.7
12	21	61.8	13	38.2	42	56.0	33	44.0	63	57.8	46	42.2
13	23	67.6	11	32.4	53	70.7	22	29.3	76	69.7	33	30.3
14	12	35.3	22	64.7	25	33.3	50	66.7	37	33.9	72	66.1

[a] 0 denotes lack of powerlessness.

[b] +1 denotes powerlessness.

The third item was job advancement. Seventeen (50%) of the auxiliary department staff nurses indicated a lack of powerlessness, and 17 (50%) indicated feelings of powerlessness. In comparison, 45 (60%) of the nursing service department staff nurses designated a lack of powerlessness, and 30 (40%) indicated feelings of powerlessness. Overall, in response to item 3, a majority (62; 56.9%) of this sample of staff nurses indicated a lack of powerlessness in job advancement.

The fourth item was organizational support provided to the employee when an individual brought ideas to improve conditions at work. Twenty-six (76.5%) of the auxiliary department staff nurses indicated lack of powerlessness in obtaining support from the organizational management, and 8 (23.5%) indicated feelings of powerlessness. Fifty-seven (76%) of the nursing service department staff nurses indicated a lack of powerlessness, while 18 (24%) indicated feelings of powerlessness. Therefore, a majority (83; 76.1%) of this sample of staff nurses specified a lack of powerlessness in obtaining support from management personnel when they suggested ideas to improve conditions at work.

The fifth item was the acknowledgment of advance career planning and goal setting or fate as keys to success. Twenty-eight (82.4%) of the auxiliary department staff

nurses indicated a lack of powerlessness in career planning and goal setting, while 6 (17.6%) indicated feelings of powerlessness. Sixty-seven (89.3%) of the nursing service department staff nurses specified a lack of powerlessness, and only 8 (10.7%) indicated feelings of powerlessness. Therefore, a majority (95; 87.2%) of this sample of staff nurses indicated a lack of powerlessness and the belief that advance career planning and goal setting rather than fate were keys to success. Only 14 (12.8%) of the nurses indicated feelings of powerlessness reflecting that regardless of career planning, some poeple receive breaks and some do not.

The sixth item was influence which individuals have to change established rules. Twenty (58.5%) of the auxiliary department staff nurses indicated a lack of powerlessness, and 14 (41.2%) indicated feelings of powerlessness. Forty-six (61.3%) of the nursing service department staff nurses specified a lack of powerlessness, and 29 (38.7%) indicated feelings of powerlessness. Therefore, a majority (66; 60.6%) of this sample of staff nurses felt a lack of powerlessness in influencing change in established rules in the organization.

The seventh item was the individual's input into the treatment program prescribed for the patients as a member

of the treatment team. Nineteen (55.9%) of the auxiliary department staff nurses indicated a lack of powerlessness, and 14 (44.1%) indicated feelings of powerlessness. Forty-one (54.7%) of the nursing service department staff nurses indicated the lack of powerlessness, and 34 (45.3%) indicated feelings of powerlessness. Therefore, a majority (60; 55%) of this sample of staff nurses indicated a lack of powerlessness and a belief that as members of the treatment team, they had input on the treatment program prescribed for the patients. Forty-nine (45%) nurses indicated feelings of powerlessness reflecting the belief that it is actually the physician who makes the decision on what type of treatment the patient will receive.

The eighth item was acquisition of a raise or promotion based on performance and knowledge rather than on luck or relationship to influential people. Twenty-seven (79.4%) of the auxiliary department staff nurses indicated a lack of powerlessness, and 7 (20.6%) indicated feelings of powerlessness. Sixty-three (84%) of the nursing service department staff nurses indicated the lack of powerlessness, and 12 (16.0%) indicated feelings of powerlessness. Therefore, a majority (90; 82.6%) of this sample of staff nurses specified a lack of powerlessness, indicating that they believed that employees receive raises or promotions based on their

individual performance and knowledge. In comparison, 19 (17.4%) of the nurses specified feelings of powerlessness. These staff nurses indicated that they believed that employees received raises or promotions because they were lucky and happened to be in the right place and knew the right people.

The ninth item was the employee's influence on the operation of the organization. Twenty-two (64.7%) of the auxiliary department staff nurses specified a lack of powerlessness, and 12 (35.3%) indicated feelings of powerlessness. Forty-seven (62.7%) of the nursing service department staff nurses indicated a lack of powerlessness, and 28 (37.3%) indicated feelings of powerlessness. A majority (69; 63.3%) of this sample of staff nurses specified a lack of powerlessness, indicating that they believed that as employees, they have influence on how things are run in the organization. Forty (36.7%) nurses indicated feelings of powerlessness reflecting the belief that they were not comfortable to make suggestions on how things should be run.

The 10th item was the input of the employees into decisions which affect them. Seventeen (50%) of the auxiliary department staff nurses indicated a lack of feelings of powerlessness, and 17 (50%) indicated feelings of

powerlessness. In contrast, 47 (68%) of the nursing service department staff nurses designated a lack of powerlessness, and 24 (32%) indicated feelings of powerlessness. A majority (68; 62.4%) of this sample of staff nurses indicated a lack of feelings of powerlessness, reflecting that they believed that they had input into the decision making of the organization. However, 41 (37.6%) of the nurses specified feelings of powerlessness. These staff nurses indicated that they did not feel that they had input into the decision making of the organization.

The 11th item was the suggestions coming from employees and the changes that occur based on these suggestions. Twenty-two (64.7%) of the auxiliary nurses indicated a feeling of powerlessness, and 21 (28%) designated a lack of powerlessness. Fifty-four (72%) of the nursing service department nurses indicated a feeling of powerlessness, and 21 (28%) specified a lack of powerlessness. The majority (76; 69.7%) of this sample of staff nurses specified feelings of powerlessness, and 33 (30.3%) indicated a lack of powerlessness.

The 12th item was the protection of the employee's professional interests, especially when they are in conflict with those in positions of power. Twenty-one (61.8%) of the auxiliary department staff nurses indicated a lack of

powerlessness, and 13 (38.2%) indicated feelings of powerlessness. Forty-two (56%) of the nursing service department staff nurses specified a lack of powerlessness, and 33 (44.0%) indicated feelings of powerlessness. Overall, a majority (63; 57.8%) of this sample of staff nurses indicated a lack of powerlessness, and 46 (42.2%) indicated feelings of powerlessness.

The 13th item was the employee's participation in making important decisions related to their work. Twenty-three (67.6%) of the auxiliary department staff nurses indicated a lack of powerlessness, and 11 (32.4%) indicated feelings of powerlessness. Fifty-three (70.7%) of the nursing service department staff nurses indicated a lack of powerlessness, and 22 (29.3%) indicated feelings of powerlessness. A majority (76; 69.7%) of this sample of staff nurses indicated that they lacked feelings of powerlessness. Thirty-three (30.3%) nurses indicated feelings of powerlessness. Their scores reflected that as employees, they have little opportunity to participate in making decisions related to their work.

The 14th and last item was the employees' participation in making institutional policies. Twenty-two (64.7%) of the auxiliary staff nurses indicated feelings of powerlessness, and 12 (35.3%) indicated a lack of powerlessness. Fifty

(66.7%) of the nursing service department staff nurses indicated feelings of powerlessness and 25 (33.3%) specified a lack of powerlessness. Both groups (72; 66.1%) indicated strong feelings of powerlessness. They indicated that they believed that the facility-wide policies were made by a few people in power and as employees, they did not have control over it. Thirty-seven (33.9%) nurses indicated lack of powerlessness. As employees, they specified that they usually participated in the institutional policies.

A Mann-Whitney U was calculated to determine the difference between the total scores of nurses employed in the auxiliary departments and those employed in the nursing service department. The results revealed a U of 1250.5 ($p=.8718$). Therefore, no statistically significant ($p \leq .05$) difference was found between the powerlessness scores of the participants in the two work settings.

A Kruskal-Wallis one-way ANOVA was computed to determine the differences in the scores of nurses classified according to demographic data with three or more levels. No significant differences in scores on the Guilbert Health Care Work Powerlessness Scale were found between nurses grouped according to marital status, education in nursing, education in other areas, ethnicity and shift worked (Table 7).

Table 7

Kruskal-Wallis[a] for Scores of Subjects on the Guilbert Health Care Work Powerlessness Scale when Grouped According to Marital Status, Education in Nursing, Education in Other Areas, Ethnicity, and Shift Worked

Variable	Chi square	p
Marital Status	0.8041	.6653
Education in Nursing	2.8644	.2342
Education in Other Areas	2.1535	.3319
Ethnicity	0.4280	.8050
Shift Worked	5.7271	.1215

[a]Converted to chi-square for large sample

A Spearman correlation coefficient was calculated to determine the relationship between the variables of age and tenure of employment of the participants and their total scores. The correlation between age and the total scores resulted in $r = -.713$; and between tenure and the total scores, the correlation resulted in $r = .064$. Neither correlation was significant at $p \leq .05$.

Cronbach's coefficient alpha was computed to assess reliability of the instrument with this group of subjects. Cronbach's alpha was .79.

Summary

In this chapter the sample used in this study and the findings from the data collected were described. The purpose of this study was to determine if there was a difference in the feelings of powerlessness among staff nurses employed in the auxiliary department as compared to the nurses in the nursing service department. The sample of 109 staff nurses who responded in this study generally indicated a lack of powerlessness. On items 11 and 14, suggestions for change from employees and employees' participation in policy determination, 22 (64.7%) of the auxiliary nurses and 50 (66.7%) of the nursing service department nurses indicated feelings of powerlessness.

Statistical analyses revealed no significant difference in the feelings of powerlessness between nurses in the two work settings. Correlations between the identified demographic variables of age and the tenure of employment and the powerlessness scores were not significant. There were no differences in the powerlessness scores of nurses when grouped according to the variables of marital status, nursing education, other education, ethnic background, and shift worked.

CHAPTER 5

SUMMARY OF THE STUDY

This study was conducted to investigate the feelings of powerlessness of registered nurses as related to their work setting and type of management. The research question was: Is there a difference in feelings of powerlessness among staff nurses employed in the auxiliary departments and staff nurses employed in nursing service departments? Seven demographic variables were analyzed in an attempt to assess any differences in powerlessness scores among nurses grouped according to these variables.

Summary

The research undertaken in this investigation is classified as a nonexperimental, cross-sectional survey. The study was conducted in a large, private teaching and metropolitan medical center hospital during the last two weeks of November, 1984. A convenience sample of staff nurses was selected, each of whom met designated criteria. Group 1 was comprised of 34 nurses from auxiliary departments, and Group 2 was comprised of 75 nurses from the nursing service department. The questionnaire used in the study was developed by Guilbert (Instruments, 1979), and the personal data sheet was developed by the investigator.

The data were analyzed using the Statistical Package for the Social Sciences (SPSS)(Nie, Hull, Jenkins, Steinbrenner, & Bent, 1975). Total scores were calculated on data obtained from the Health Care Work Powerlessness Scale. The descriptive statistics of frequencies, percentages, ranges, and means were utilized to describe the data. The Mann-Whitney U test was used to analyze the differences between the total scores of the two groups of nurses. The Kruskal-Wallis one-way ANOVA was employed to determine whether or not there were differences in the total scores of nurses when grouped according to the variables of marital status, education in nursing, education in other areas, ethnic background, and shift worked. Spearman correlations were computed to analyze whether or not there was a relationship between the demographic variables of age and tenure and the total scores of nurses on the powerlessness scales.

The findings of this study indicated that the feelings of powerlessness among staff nurses were not significantly different for nurses working in auxiliary and nursing service departments. There were also no significant differences in total scores for nurses grouped according to marital status, education in nursing, education in other areas, ethnic background, and shift worked. No significant relationship was found between the variables of age and tenure and scores on the powerlessness scale.

Discussion of Findings

As technology continues to advance, more and more nurses are working outside of the structured nursing service department. New roles have emerged in the nursing profession in response to the need for providing the best care that patients could possibly receive. The first level position for professional nurses in a general hospital setting or in the auxiliary department of any hospital is that of a staff nurse. For this particular study, the investigator included the staff nurses employed in the auxiliary departments who were not under nursing management and the staff nurses who were under the management of nursing service departments.

The research question was based on previous research findings which supported a significant relationship between centralization, formalization, and alienation (Aiken & Hage, 1966), powerlessness and job complexity (Blauner, 1964; Tudor, 1972), role transformation (Lewandowski & Kramer, 1980), organizational control and alienation (Miller, 1967), differences in relationships with superiors and the presence of group norms and unity (Pearlin, 1962), achievement of control-relevant knowledge (Seeman, 1963, 1966, 1967a; Seeman & Evans, 1962). The variables just cited exist in varying degrees in the two departments. The findings of

this study indicated that regardless of work setting and type of management, the participants felt a lack of powerlessness. Furthermore, in considering the demographic variables of age, education in nursing, education in other areas, marital status, ethnic background, shift worked, and tenure of employment, no significant relationship was evidenced. There were also no differences in scores when subjects were grouped according to education in nursing, education in other areas, marital status, ethnic background, and shift worked.

The resultant scores of both groups of sampled staff nurses indicated that they felt a lack of powerlessness. The nurses indicated that they perceived themselves as having control and influence in their work areas. However, an item-to-item analysis of the questionnaire revealed two areas in which both groups of staff nurses indicated feelings of powerlessness. The two areas were: (1) question #11 which was related to the area of influence in bringing about needed changes in the work area; and (2) question #14 which was related to the employees' participation in determination of facility-wide policies. The participants indicated that they felt powerless in offering valid complaints about their work situation and in contributing to decisions about policies.

Conclusions and Implications

Due to a limited period of data collection, and the homogeneity of this sample, the findings should not be generalized beyond the subjects who participated in this study. The following conclusions were made:

1. Auxiliary and nursing service department staff nurses tend to feel that they have control of their work environment.
2. The issues of bringing about needed change and participation in hospital-wide policy making decisions are ones about which participants experienced feelings of powerlessness.
3. The feelings of power/powerlessness do not differ between nurses in auxiliary and nursing service departments.
4. The feelings of power/powerlessness in the work environment are not affected by the demographic variables of age, nursing education, non-nursing education, marital status, ethnicity, shift, and tenure of employment.

Based upon these conclusions, the following implications are proposed:

1. Since feelings of powerlessness do not differ among nurses employed in the auxiliary and nursing service departments, unification of all nurses under the nursing

service department could seemingly be undertaken without affecting the nurses' feelings of powerlessness.

2. Included in the organizational restructuring should be revisions that would facilitate participation by staff nurses in bringing about needed changes and in decisions regarding institutional policies.

Recommendations for Further Study

From the findings of this study, the following recommendations are made:

1. This study should be replicated including male nurses in the sample.
2. Replication of this study is recommended to include a larger sample from each work area.
3. It is recommended that a study be conducted to investigate feelings of power/powerlessness in various types of hospital systems.
4. A study should be conducted to compare the feelings of power/powerlessness of nurses at various hierarchical levels.

APPENDIX A

AGENCY PERMISSION FOR CONDUCTING SURVEY

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING
DENTON, TEXAS 76204

DALLAS CENTER
1810 INWOOD ROAD
DALLAS, TEXAS 75235

HOUSTON CENTER
1130 M.D. ANDERSON BLVD.
HOUSTON, TEXAS 77030

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE _____

GRANTS TO JOANNA V. PO

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem:

To determine if there is a difference in the feelings of power/ powerlessness among staff nurses employed in auxiliary departments as compared to staff nurses in nursing service departments.

The conditions mutually agreed upon are as follows:

1. The agency ~~(may)~~ (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency ~~(may)~~ (may not) be identified in the final report.
3. The agency (wants) ~~(does not want)~~ a conference with the student when the report is completed.
4. The agency is (willing) ~~(unwilling)~~ to allow the completed report to be circulated through interlibrary loan.
5. Other: _____

Date: 10/29/84

Signature of Agency Personnel

Joanna V. Po
Signature of Student

Signature of Faculty Advisor

*Fill out and sign three copies to be distributed as follows: Original-Student; First Copy-Agency; Second Copy-TWU College of Nursing.

APPENDIX B

COVER LETTER AND QUESTIONNAIRE

Dear Colleague,

As a graduate student in nursing at the Texas Woman's University, I am investigating personal feelings among staff nurses. Your participation in this study would be helpful in gaining insight into ways in which nurses view their work settings.

You have been identified as a person who might contribute significant knowledge to this study. Your name was selected from a list of staff nurses obtained from your clinical area manager. I am asking your assistance in completing the enclosed Data Form and the questionnaire, which will require about 15 to 30 minutes of your time. Permission to conduct this study has been obtained from the Human Subjects Review Committees of your institution and the Texas Woman's University. Your responses will be confidential. A code number is placed on the questionnaires instead of your name. Your identity will not be revealed in any publication or report of the results or to anyone. Data obtained will be used only for purposes of nursing study and research. The single master code sheet with code numbers and names will be destroyed upon completion of this study.

Participation in this study is voluntary and your decision to participate or to refuse to participate will in no way affect you or your occupational status. You may withdraw at any time. Please note that, although no injury is predicted, in the event of injury as a result of this study, no medical services or compensation will be provided by Texas Woman's University. YOUR WILLINGNESS TO PARTICIPATE IS IMPLIED BY THE RETURN OF THE COMPLETED QUESTIONNAIRE.

Please place your completed questionnaire in the attached envelope and place it in the box for collection.

Thank you for your time and participation. If you have any questions, please feel free to call me at 498-8306.

Sincerely,

Joanna V. Po

Joanna V. Po, RN

Instructions for Completing the Following Questionnaire

For this section of the study you are asked to select ONE statement from each pair of statements which you more strongly believe to be true. It is quite possible in some cases that you really agree with either statement of the pair. In these cases, please check the one statement which comes closer to expressing the way you feel.

Please check only ONE statement from each pair. Be sure to check the one which you actually believe to be more nearly true, rather than the one you think you "should" check or the one you would like to be true.

It is important to this study that you choose one statement from each pair. PLEASE DO NOT OMIT MAKING A CHOICE FROM ANY PAIR.

Remember, there are no "right" or "wrong" choices. It is your individual opinion that is important to this study. When the statement includes the words "this facility" it is in reference to the hospital in which you are employed.

GUILBERT'S HEALTH CARE WORK POWERLESSNESS SCALE

1. _____ When a person works for a large organization such as this facility, that person has little chance of exerting any real influence on working conditions.

   _____ Even in a large organization such as this facility, the individual can have a real influence on working conditions, if that individual makes her ideas known.

2. _____ The type of treatment program a patient receives is decided by the doctor; there's very little anyone else can do except go along with it.

   _____ Everyone who works with patients here can have a real influence on what treatment approach will be used.

3. _____ Some people are just lucky and seem to advance in their jobs by simply being in the right place at the right time.

   _____ Many people don't realize how much the cause of their failure to get ahead in their jobs is the result of their work performance.

4. _____ It doesn't do much good to try and think of ways to improve conditions at work; you really can't try new ideas anyway.

   _____ If you have a good idea about some way to improve conditions at work, you can usually get the backing you need to try it.

5. _____ It does little good to plan one's career too far ahead; some people get the breaks and some don't.

   _____ People are better off if they plan their careers and set goals for themselves rather than trusting to fate.

6. _____ Individuals can influence in established rules at this facility, if they make their needs known.

_____ Established rules at this facility can't be changed for an individual's needs or problems.

7. _____ As a member of this treatment team I can have a real influence on the treatment program prescribed for the patients.

_____ Even though I am considered a member of this treatment team, it is really the doctors who decide what treatment the patient will receive.

8. _____ Whether or not a person gets a raise or promotion in their job depends mostly on luck and knowing the right people; there's really not much the individual can do about it.

_____ Whether or not a person gets a raise or promotion in their job depends mostly on whether that individual is well prepared and does a good job.

9. _____ I think people like myself have an influence on how things are run here.

_____ It's rather silly to ask someone like myself to make suggestions about how things should be run here; people seldom pay attention to them.

10. _____ When decisions are being made at this facility, the opinions of the people affected by that decision do have an affect on what's decided.

_____ When decisions are being made at this facility, the opinions of the people affected by them have little influence on what's decided.

11. _____ Offering valid complaints about one's work situation here is usually helpful in bringing about needed changes.

_____ Offering valid complaints about one's work situation here doesn't seem to do much good.

12. _____ Persons like myself have little chance of protecting our professional interests in this job when they conflict with those in the positions of power.

_____ I feel we have adequate ways of coping with those in the positions of power in this facility and can protect our own professional interests.

13. _____ Employees in this facility can usually participate in making important decisions related to their own work.

_____ Individual employees have little opportunity to participate in making decisions related to their own work.

14. _____ Facility-wide policies are made by those few people in power, and there is not much the individual employee can do about it.

_____ The individual employee can usually have an influence on facility-wide policies.

PERSONAL DATA SHEET

Please indicate your answers by filling in the blank or by placing a check in the parenthesis corresponding to the appropriate response. Please check only ONE answer for each question.

1. Sex: Female ()

2. Marital Status: Never Married () Married () Widowed ()

   Divorced () Separated ()

3. Age:_____

4. Highest level of nursing education: Diploma ()

   Associate Degree () Bachelor of Science ()

   Master of Science () Doctorate ()

5. Highest level of education in area other than nursing:

   Associate Degree () Bachelor of Arts or Bachelor of Science ()

   Master of Arts or Master of Science () Doctorate ()

6. Ethnic Origin: Please Specify: _____

7. Employment Status: Full-time () Part-time ()

   Special Schedules (i.e. rotation, 32 hour weekend) ()

8. Type of Position: Supervisor or Assistant () Instructor ()

   Head Nurse or Assistant () Clinical Specialist ()

   Staff or General Duty ()

9. Area of Employment: General Medical Unit ()

   General Surgical Unit () Circulatory Dynamics ()

   Internal Medicine () Hemodialysis () Radiology ()

   Cardiology Diagnostic () Hypertension () Peripheral Vascular ()

   Pulmonary () Other (please specify) _____

10. Shift Rotation: Day () Evening () Night () Variable ()

11. Date when you began work in present setting:_____

APPENDIX C

CORRESPONDENCE WITH AUTHOR OF INSTRUMENT

9 November 1983

Evelyn K. Guilbert, R.N., M.S.
University of California at Los Angeles
School of Nursing
Los Angeles, California 90024

Dear Ms. Guilbert,

I am a graduate student at Texas Woman's University in Houston, Texas and currently enrolled in a thesis proposal course. In partial fulfillment of my master's degree in nursing, I am proposing to do my thesis on the perception of powerlessness among staff nurses employed in the various work areas. I am requesting permission to utilize the Health Care Work Powerlessness Scale that you have developed. In addition, I am requesting any further information regarding the reliability and validity of your instrument.

I am looking forward to hearing from you.

Sincerely yours,

Joanna V. Po

Joanna V. Po, R.N.
12226 Scottsdale Drive
Stafford, Texas 77477

Terry Throckmorton

Terry Throckmorton, R.N., M.S.
Thesis Committee Chairperson

BIOLA UNIVERSITY

January 10, 1984

Joanna V. Po, R.N.
12226 Scottsdale Drive
Stafford, Texas 77477

Dear Joanna:

My sincerest apologies for the delay in responding to your request for use of my Health Care Work Powerlessness Scale. A prolonged bout with illness plus my husband's becoming ill and a heavy work load to try to stay up with have all contributed to my falling way behind in responding to correspondence. I am sorry for any inconvencience my delay has caused you.

I would be pleased to allow you to use the instrument in your thesis research. There is one stipulation that I do make, however. I do require a copy of your final research report. This enables me to stay abreast of the research being done with my scale. If you are willing to furnish this copy of your research, you may use the scale.

Please let me know if you are still interested. I will forward to you some additional information about the scale. Reliability has been consistently high. Some additional work has been completed toward establishing the validity of this instrument.

Again, my apologies for the delay. Good luck with your research.

Yours truly,

Evelyn K. Guilbert, R.N., M.S.N.
Associate Professor

P.S. I am returning your check for $5.00. Thank you for including it, but I provide the information I can about the instrument and allow its use without charge. My "charge" is the copy of your final research report.

Also, Joanna, my home address is: 10139 Monogram Avenue, Sepulveda, CA 91343. My home phone is: (818) 363-6057; my office phone is: (213) 944-0351, ext. 3458. Feel free to contact me if I can help.

E

January 31, 1984

Evelyn K. Guilbert, R.N., M.S.N.
10139 Monogram Avenue
Sepulveda, CA 91343

Dear Mrs. Guilbert:

I was so glad to receive your reply. I am sorry to hear about your prolonged illness. I hope that you have fully recovered from it.

I am still very interested in using the "Health Care Work Powerlessness Scale" that you have developed. Upon completion of the study, I will send you a copy of my final research report.

With sincere appreciation,

Joanna V. Po

Joanna V. Po,

JVP/lb

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