READINESS FOR CONTINUED LEARNING AND EMPOWERED NURSING PRACTICE AMONG GRADUATING NURSING STUDENTS OF ASSOCIATE AND BACCALAUREATE DEGREE PROGRAMS

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READINESS FOR CONTINUED LEARNING AND EMPOWERED NURSING
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by

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(ABSTRACT)

The critical shortage of competent nurses,
disillusionment, and high attrition rate among graduates
entering the workforce provided the impetus for this
investigation. The purpose of this study was to determine
the perceived level of empowerment among graduating nursing
students of two basic nursing educational programs and the
relationship of empowerment to selected variables. The
selected variables were self-directed learning readiness,
self-esteem, level in the program, and demographics. In
addition, predictors of empowerment were investigated.

A sample of 294 nursing students of associate and
baccalaureate degree programs from five schools of nursing
in the Mid-Atlantic region participated in the study.
Instruments used were the Vincenz Empowerment Scale, Self-
Directed Learning Readiness Scale, and Self-Esteem Inventory
and a data sheet for demographics. The survey was completed
from June to September 1994.

Nursing students in general perceived themselves to
have fairly high levels of empowerment, self-directed
learning readiness, and self-esteem which was significantly higher for graduating students as compared to freshman students. There were no significant differences among the variables under study between baccalaureate and associate degree students or the type of institution they represented as private or public. Similarly, there were no differences in their perceived levels of empowerment, self-directed learning readiness, or self-esteem based on gender, racial/ethnic background, or affiliation with Student Nurses' Association. The wide variation in age and educational background ranging from high school to graduate degrees were associated with the participants' levels of self-directed learning readiness and self-esteem. In addition, participants who were involved in community organizations reported higher levels of empowerment. Regression analysis indicated self-directed learning readiness and self-esteem contributed significantly to the variance in empowerment.

The findings add to the empowerment literature.

Implications for nursing education include: (a) enhancing students' level of self-directed learning readiness and self-esteem may assist in empowering them, and (b) the basic educational process plays a significant role in nursing students' perceived levels of empowerment.
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TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>ii</td>
</tr>
<tr>
<td>Acknowledgments</td>
<td>iv</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>viii</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>ix</td>
</tr>
<tr>
<td><strong>CHAPTER</strong></td>
<td></td>
</tr>
<tr>
<td>I. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Background of the Problem</td>
<td>7</td>
</tr>
<tr>
<td>Statement of the Problem</td>
<td>16</td>
</tr>
<tr>
<td>Purpose</td>
<td>20</td>
</tr>
<tr>
<td>Research Questions</td>
<td>20</td>
</tr>
<tr>
<td>Significance of the Study</td>
<td>21</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>22</td>
</tr>
<tr>
<td>Assumptions</td>
<td>23</td>
</tr>
<tr>
<td>Limitations</td>
<td>23</td>
</tr>
<tr>
<td>Organization</td>
<td>24</td>
</tr>
<tr>
<td>II. REVIEW OF LITERATURE</td>
<td>25</td>
</tr>
<tr>
<td>Empowerment</td>
<td>25</td>
</tr>
<tr>
<td>Empowerment in Nursing</td>
<td>29</td>
</tr>
<tr>
<td>Empowerment in Nursing Education</td>
<td>41</td>
</tr>
<tr>
<td>Demographic Variables</td>
<td>46</td>
</tr>
<tr>
<td>Age</td>
<td>47</td>
</tr>
<tr>
<td>Gender</td>
<td>47</td>
</tr>
<tr>
<td>Racial/Ethnic Background</td>
<td>49</td>
</tr>
<tr>
<td>Educational Background</td>
<td>51</td>
</tr>
<tr>
<td>Work Experience and Community Involvement</td>
<td>51</td>
</tr>
<tr>
<td>Self-Directed Learning Readiness</td>
<td>52</td>
</tr>
<tr>
<td>Self-Esteem</td>
<td>59</td>
</tr>
<tr>
<td>Theoretical Framework</td>
<td>63</td>
</tr>
<tr>
<td>Summary</td>
<td>65</td>
</tr>
<tr>
<td>III. METHOD</td>
<td>67</td>
</tr>
<tr>
<td>Research Design</td>
<td>67</td>
</tr>
<tr>
<td>Population and Sample</td>
<td>68</td>
</tr>
<tr>
<td>Instruments</td>
<td>71</td>
</tr>
<tr>
<td>Vincenz Empowerment Scale</td>
<td>71</td>
</tr>
<tr>
<td>Self-Directed Learning Readiness Scale</td>
<td>72</td>
</tr>
<tr>
<td>Self-Esteem Inventory</td>
<td>75</td>
</tr>
<tr>
<td>Demographic Data</td>
<td>75</td>
</tr>
<tr>
<td>Procedures</td>
<td>76</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>77</td>
</tr>
</tbody>
</table>
LIST OF TABLES

<table>
<thead>
<tr>
<th>TABLE</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Response Rate and Distribution</td>
<td>81</td>
</tr>
<tr>
<td>2</td>
<td>Distribution of Sample according to Type of Institution, Program and Level</td>
<td>82</td>
</tr>
<tr>
<td>3</td>
<td>Demographic Characteristics</td>
<td>85</td>
</tr>
<tr>
<td>4</td>
<td>Means, Standard Deviation and ANOVA Results for Program and Level</td>
<td>91</td>
</tr>
<tr>
<td>5</td>
<td>Mean, Standard Deviation and ANOVA Results and Demographics</td>
<td>92</td>
</tr>
<tr>
<td>6</td>
<td>Correlation between Variables</td>
<td>96</td>
</tr>
<tr>
<td>7</td>
<td>Results of Regression Analysis</td>
<td>100</td>
</tr>
<tr>
<td>8</td>
<td>Multiple Regression Analysis</td>
<td>101</td>
</tr>
</tbody>
</table>
## LIST OF FIGURES

<table>
<thead>
<tr>
<th>FIGURE</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Proposed Theoretical Model</td>
<td>66</td>
</tr>
<tr>
<td>2 Design for the Study</td>
<td>69</td>
</tr>
<tr>
<td>3 Age Distribution</td>
<td>84</td>
</tr>
<tr>
<td>4 Prior Education</td>
<td>88</td>
</tr>
<tr>
<td>5 Empowerment Subscales by Program and Levels</td>
<td>94</td>
</tr>
</tbody>
</table>
CHAPTER I

INTRODUCTION

The health care system in the 1990s may be characterized as one of unrelenting change, increasing complexity, and high costs. The half life of professional knowledge is estimated to be as short as two to three years (Livneh, 1988). The nursing profession is growing ever more complex within this rapidly developing health field. For nurses to remain as competent and responsible practitioners, they need to assume responsibility for their lifelong learning. As the American Nurses' Association (ANA) points out, "Continuing education makes us cognizant of our continual need to know and the inevitability of obsolescence should we cease to learn and grow" (ANA, 1979, p.6). In addition, society demands both a high degree of accountability and high quality health care at low cost. To fulfill these increasing demands, nurses have a professional responsibility to maintain their competence and to provide quality health services. Zest for continued learning and participation in continuing education activities are prerequisite to the knowledge and skill acquisition increasingly required of the professional nurse (ANA, 1979; Carpenito, 1991b; Cooper, 1980).

In a health care field where change is the constant, an increasingly sophisticated professional is needed not only
to deal with the technological explosion in health care, but also with the more sophisticated needs of clients as the latter become more and more personally involved in self-care and/or care of their own family members (Watson, 1988; O'Leary, 1986; Cohen & Jorden, 1988). This is especially true today due to the heightened acuity level of patients status and the shorter duration of their stay in episodic settings. Thus, not only do the clients need sensitive and competent caring, but they also need teaching and guidance to increase their self-reliance and independence in managing their health needs and reaching their fullest level of wellness.

Nurses function in a variety of settings, confront various levels of problems and a wide range of ages, cultures, health beliefs, and individual expectations in the practice of professional nursing. Clinical judgment is a critical component of their practice. Clinical judgment is the process of translating the knowledge and observations into a plan of nursing action, and the implementation of that plan for the benefit of the client. Nurses must, therefore, develop and maintain the knowledge, skills, and clinical competence that are essential for clinical judgment. This comes with commitment and continued learning.
The role of the nurse involves prevention of illness, promotion of health and maximizing the physical, functional, and psychosocial status of clients in her/his care. In addition, the nurse is concerned with the health of the family and community members that may affect the health status of her primary patient, as well as collaborating and assisting other health care providers in the delivery of health care (Kerfoot, 1990). Thus, the nursing professional we seek today is "one who acts and reflects and [is] a compassionate scholar with a mind that never ceases to inquire, quest and expand" (Bevis & Watson, 1989, p. 68). They are empowered practitioners with a sense of being in charge of their lives, capable of effective involvement with their environment whether it be occupational, interpersonal, social, political, or spiritual (Hawkins, 1992). Empowered nurses see themselves as meaningful and respected, and take pride in their contribution. They are committed to their work and gain satisfaction and fulfillment from it (Baughn, 1991).

The rapidly changing health care system has created or intensified many critical problems for the nursing profession which are interrelated and complex (Hawkins, 1992; Stevens, 1983). There is a severe shortage of qualified nurses. Increasing numbers of nursing graduates entering practice are experiencing dissatisfaction and
alienation, which is resulting in an attrition rate as high as 20 percent within the first two years of practice. More importantly, many nurses who fail to see the importance of maintaining their clinical proficiency in order to be productive practitioners lack self-confidence, self-esteem and competence (Kramer, 1974; Hawkins, 1992).

Nursing education is often cited for its failure to prepare nurses who are capable of responding adequately to the demands of the work world, and who recognize the importance of maintaining their competence through lifelong learning (Millonig, 1985; Carpenito, 1991a). Nurse educators cite a discrepancy between the professional values and ideals developed and internalized within the academic environment and those encountered and perpetuated in the workplace. These discrepancies often negatively affect the nurse's self-concept. The educators believe that this discrepancy is the result of the prevailing bureaucratic work system and the relative inefficiency of the health care system, as well as the long history of powerlessness experienced by nursing professionals (Hersky & Duldlt, 1989).

Hospitals, where a majority of the nation's nurses are employed, are large bureaucratic institutions with their own sets of rules and obligations. The major goal of the hospital in the 1990s is to conduct its business as cost effectively as possible. Typically the bureaucratic
hospital administration is expected to assure the availability of all services potentially needed by its clients, the physician is expected to select the medical services to be delivered, and the nurse is expected to execute and monitor the delivery of these services often at the expense of meeting health care needs of patients inadequately (Carlson-Catalano, 1988; Rosenow, 1983; Thompson, 1982).

The bureaucratic role of the nurse emphasizes the fact that nurses must carry out the orders and directives of three administrative entities: the hospital; the physician; and the nursing administration. This bureaucratic role may conflict with nurses' professional contract with the client in which the client and not the directives of others is the central focus of nursing. Attempting to fulfill the demands of many bosses whose focus is on quantity and medical rather than health care, professional nurses often feel that they do not have enough time to provide quality health care to their clients. They feel unappreciated and underused, and feel frustration rather than fulfillment. These feelings lead to low morale and disenchantment with their job (Kramer, 1974; Prescott & Dennis, 1985; Kafelian, 1985; Carlson-Catalano, 1988).

Because nursing is primarily a female dominated profession, the dual effects of sex stereotyping and gender
role expectations have continued to serve as restraints to personal and professional power. Typically, members of oppressed groups engage in complaining and submissive behaviors. They experience low self-esteem and self-hatred, and therefore, allow continued subordination (Roberts, 1983). In the workplace, nurses lacking status and prestige are seen primarily as extenders of physicians. They are not seen as providing unique services nor as using complex cognitive skills (Watson & Burkholder, 1990; Reichett, 1988; Watson, 1988; Weiss, 1984; Roberts, 1983). As a result, nurses experience a conflict between ideals of the profession and the current reality of the work world. This conflict leads many nurses to leave nursing practice or become mediocre practitioners. Nursing has a unique contribution to make in the health care system. In order for them to provide the best of which they are capable of, they need to be empowered. Only empowered nurses can empower their clients to gain control over their health and well being (Gibson, 1991).

One area where very little research has been conducted to date is how professional education can empower nurses to remain competent in their practice through continued learning and to confront the real world of practice as change agents rather than remain as numbers of an oppressed group. Brown aptly pointed out that "tomorrow's illiterates
will be those who have not learned how to learn" (cited in Thurston, 1992, p.9). It is thus important to have a curriculum model that challenges nursing students to become self-directed, lifelong learners who are consistently safe, competent, and confident in their nursing practice (Callahan, 1992). Nursing education is recognizing and responding to that challenge. Project 2000, with its emphasis on elevating educational standards, is one example of that recognition (Dolan, 1993). Nursing education is undergoing major changes in both curriculum and instructional methods. Much rests on how nursing education is preparing nursing students to become professionals capable of meeting the demands of the "real world" of practice. Vance (1985) has noted that, "Whether these future nurses eventually become satisfied and committed professionals or unhappy, disillusioned dropouts will depend, to a large extent on our understanding and guidance of them in this professional development period" (p. 21).

**Background of the Problem**

Nursing education has not historically taught empowerment, but rather obedience and subservience (Rosenfield, 1986; Hawkins, 1992). Early schools of nursing were under the auspices of hospitals. By maintaining control over schools of nursing, hospitals were guaranteed a
free labor force. Student nurses staffed the hospitals, and they worked in exchange for room, board, and instruction. Even though hospital schools flourished, their educational components did not get high priority. Recommendations for any changes in nursing education received minimal support as such changes might have given hospital administrators less control over nursing students. Society's attitude toward both the role and higher education of women also contributed to this general inertia (Chaska, 1990).

By the mid-20th century, nursing education was typically a three-year diploma program. Graduates were skilled in carrying out the tasks associated with bedside care and in assisting physicians with procedures. The transfer of nursing education from medically oriented hospitals to colleges where the development of professional nursing could more readily occur took a very long time even though the first such school was established in Minnesota in 1909 (Kalish & Kalish, 1986). By 1940, there were 76 baccalaureate nursing programs in the United States. The concept of technically oriented nursing curricula was born in the early 1950s, when small community-based junior colleges began to flourish. The resulting two-year program was intended to prepare technically competent bedside nurses. Thus, by the 1950s, there were three primary avenues to becoming a registered nurse: (a) a four-year
college or university program leading to a baccalaureate degree, (b) a two-year junior college program leading to an associate degree, and (c) a two- to three-year hospital-based program leading to a diploma. To this day, the three modes of educating nurses continue. All three groups are allowed to write the state board examination to become registered nurses. These different educational routes have resulted in diversity among nurses in terms of their abilities, knowledge base, skills, theoretical approach to practice, professional identity, and collegiality.

In 1965, the American Nurses Association (ANA) adopted a resolution that the BSN degree be the minimum educational requirement for professional nursing practice. Since that time, diploma schools have steadily declined and college and university programs have taken over their place. By 1992, there were over 400 BSN programs and 776 associate degree programs in the United States. However, the ANA resolution had very little impact on differentiating the role of nurses in the workplace. Today, there are more associate degree graduates than baccalaureate prepared nurses who function as registered nurses with no differentiation in their work assignment (Chally, 1992; Baily, 1992; Chavasse, 1992). Due to lack of research on the topic, it is unclear whether educational preparation influences the relative levels of empowerment of registered nurses.
The program of education is not the only factor that influences the type of professional that nurses eventually become. Other factors include the method of instruction, attitudes of students and faculty, the interactions with the faculty, and the role models the students have, both in the educational setting and in their professional careers. For example, traditionally, many nursing educators have subscribed to a patriarchal world view, resulting in nursing students being treated like military recruits (Chally, 1992). Loyalty, obedience, and submissive behavior have been encouraged. Students have been expected to follow teachers' directions to the letter, memorizing information and practicing skills with unquestioning obedience. In this process, teachers have often failed to instill vision, meaning, and trust in their students, and have instead bred powerlessness and dependency (Chavasse, 1992; Carpenito, 1991a, & 1991b; Chally, 1992; Reverby, 1987; Bevis & Watson, 1989).

The American Association of Colleges of Nursing (AACN) produced a report in 1980 on essential values for an educated person and educated nurse. The report brought national focus to a "value dimension" of nursing education. The National League for Nursing (NLN) sponsored a series of nurse educator conferences in 1987, 1988, and 1989 on curriculum revolution, and raised issues that mandated
significant change in nursing education. The common theme was a renewed emphasis on nursing's essential role, mission, commitment, and function of human caring. The conferences called for a shift from training to education, from technique to understanding, from product line thinking to value based human caring education. They recommended a curriculum concerned with the "release of human creativity, freedom, critical thinking and a development of a new consciousness and morality for nursing education and expert human caring practices" (Bevis & Watson, 1989, p. 61). The assumptions underlying this type of education are two-fold: that such a curriculum would regard education as a liberating experience in which the learner is an active participant in the learning process; and that the teacher acts as a facilitator to enhance student self-structure and maturity. Based on extensive studies in curriculum development, Bevis and Watson (1989) have pointed out that, as students move to a higher learner maturity level, they gain greater self-structure and require little or no external motivation to continue to learn. They leave with greater self-directed learning readiness and improved self-worth and are empowered to continue to enlighten themselves, and to empower others with whom they interact (Bevis & Watson, 1989).
Nursing is witnessing a new trend in terms of the nature of the candidates now entering the field. There is a dramatic increase in nontraditional students compared to traditional high school graduates. During the period of 1975-1985, the undergraduate rate of growth of 22 percent for the 18-22 age group was exceeded by almost twice that rate by the older 25-34 age group (Chaska, 1990). More recent observations indicate a wider variation in educational level and work experiences as well. Many adult students are seeking nursing as a second career and have degrees and work experiences in other fields. According to a national survey report published in 1990, 47.4 percent of the students were reported to have a baccalaureate or higher degree prior to starting their basic professional preparation in nursing (Gruca, 1994). However, whether the additional education and maturity is related to these students' levels of empowerment and commitment to the nursing profession has not been established.

There has been a slight increase in the number of male students entering the nursing profession but that population is still less than 2 percent (Chaska, 1990). Because men are traditionally believed to be more assertive and autonomous than women, their level of empowerment may deviate from the norm. It has been documented that men entering nursing tend to choose occupational areas where
role strain is likely to be low, where no special clothing that labels them as nurses is needed, and where they have greater autonomy (Muff, 1982). Many cultures are now represented in nursing as well. Cultural background may have an influence on role perception due to internalized differences in the image of nursing and pedagogical experience.

Self-esteem is considered by many to be one of the most important determinants of one's success in life (Ellis, 1980). Both empirical evidence and observation of nursing administrators point to low levels of self-esteem and self confidence in many nurse graduates (Ellis, 1980; Burgess, 1980; Murray, 1983). Nursing education needs to focus on building self esteem by capitalizing on the capabilities of the students. One implication of this approach would be to establish admission standards that would allow only those that are likely to succeed to be admitted to the program (Hamner & Tufts, 1985).

Self-direction in learning can be viewed as a learner control continuum in which the learner gradually weans away from teacher control toward personal autonomy (Guglielmino, 1977). Candy (1991) distinguished three meanings of the term self-directed learning: autonomy as a personal quality, autodidaxy as learning outside formal instruction, and learner control as an essential consideration for formal
instruction. Houle (1980) suggests that a criterion for entrance into a profession should be potential for life-long learning. Readiness for self-directed learning is thus associated with the skills and attitudes one possesses for self-directedness in learning; the emphasis is on autonomy and personal development from a life-long learning perspective. According to Knowles (1975), self-direction in learning can be increased in most persons. Educational institutions can facilitate such an increase so that learners may utilize and develop their fullest potential (Guglielmino, 1977). Research in adult education and nursing literature indicate that self-directed learning readiness is associated with age, education, gender and culture (Sabbagian, 1979; Cafferella & O'Donnell, 1987; Linares, 1989; Brockett, 1985).

There are indications that educational institutions for nursing students are attempting to change, and recognize both the humanity of students and the potential. Adult education principles are now being adopted into nursing curricula. The old assumptions of power over the student are losing their relevance. Teachers and administrators are increasingly recognizing that they cannot merely fill the students with facts and figures and expect them to make critical decisions. Empowerment through teaching, however, will liberate students and enable them to gain their fullest
potential (Chally, 1992). Empowerment is both a process and a product. As a process, "empowerment is providing opportunity and resources to build, develop or increase the ability and effectiveness of others" (Hawks, 1992). The works of Dewey, Lewin, Rogers, and Freire provide the philosophic support for the empowerment of learners (Hawks, 1992). Several researchers have identified antecedents to empowerment as a nurturing environment of mutual respect and trust, openness, genuineness, good interpersonal skills, courtesy, and a shared vision. The person to be empowered must be willing to assume responsibility and participate in the decision making. As a product, the empowered person has an increased ability to set and reach goals for individual and social ends. The skills and attitude for self-directed learning readiness, for lifelong learning, and for meaningful work are thus ensured. As Bevis and Watson (1989) points out:

Real education is liberating, it is empowering, it provides the tools for maturity in judgment and compassion that are translated into action, and a reality view of the world that combines power with control, ability and skill with composure, and caring with firmness and resolution. (p. 308)

In summary, in this information era, continuing lifelong learning is of paramount importance to professional nursing practice in order to face its obstacles and to meet its changing challenges. As Florence Nightingale, the
founder of modern nursing, wrote "Let us never consider ourselves as finished nurses... we must be learning all our lives" (cited in Cooper & Hornback, 1973, p. 19). Through professional socialization, the student of professional nursing develops a sense of identity and commitment to the profession by internalizing the norms, values, knowledge and skills empowered to continue the ideals of practice. It is clear that empowerment is both desirable and possible through education. What is less clear is how successful nursing education in its current form is in achieving this outcome.

Statement of the Problem

One of the major difficulties facing nursing as a profession in this era of rapid change is the maintenance of the high level of expertise required of its members. It is vitally important for nursing educators to ensure that those who practice nursing have the skills and values needed to continue to learn and remain professionally proficient. Employers are spending large sums of money and mandating participation in continuing education, but the effect on practice is inconclusive (Thurston, 1992).

New graduates experience reality shock on entry into the work force (Kramer, 1974, 1985; Kelly, 1993). Well qualified professional nursing graduates have difficulty
operationalizing nursing activities in a bureaucratic hospital setting due to inherent conflicts in the value system. Many leave nursing out of frustration as they feel underused and unable to do a quality job. Others conform to the bureaucratic value system and remain as practitioners with a mediocre level of competence. Yet a third group succeeds in the nursing profession in spite of the conflicts they face in the work world, and are able to grow and self-actualize. A nationwide study conducted by Gother and Hanner (1990) concluded that the nurses who had the highest level of satisfaction with the quality of their work life and who continued to excel in practice were those with skills to think, learn and be creative. Gother and Hanner described this group as empowered, self-directed learners with high self esteem, autonomy in practice and collegial interaction with health team members. They were efficient problem solvers who found creative ways to continue to learn.

Similar findings were also reported by Kramer and Schmalenberg (1993) based on a study of magnet hospitals. The Magnet-Hospital Study showed a strong relationship between empowerment and excellence in nursing, cost-effective, quality health care to clients and their families, and fulfillment and satisfaction for nurses. This was the first and only study that assessed the quality of
nursing alone as a measure of "goodness" or quality of the hospital. Evidence of autonomous empowered behavior among nursing personnel of all levels was one of the critical factors required to gain the "magnet hospital" status. The nurses were highly competent, functioned with a strong sense of trust, and were free to voice concerns and failures as well as make decisions. They had accepted responsibility for integrating their professional and personal lives in order to constantly maintain and upgrade their competence. The benefits of empowerment were far greater than those immediately felt by the clients, hospital administration, physicians and nurses; it gave greater attention to what nursing is all about.

Nursing education has a responsibility to prepare its graduates in their maturing process to be self-directed learners, to empower them and to liberate them in realizing their potential and their responsibility. A curriculum revolution is now in progress, as evidenced by the recent emphasis placed by the American Nurses Association and the National League of Nursing on providing an environment that is conducive to preparing self-directed, empowered nurses who will be lifelong learners and proficient practitioners. There have been heightened discussions of empowerment methodologies in the recent literature in nursing as well. Many educational institutions have professed their belief in
the professional role of the nurse and the importance of lifelong learning, but how far such belief is fostered in the students they teach is unclear. All graduates are tested for their skills and knowledge to begin practice but there is no empirical evidence whether the graduates experience empowerment or possess self-directed learning readiness.

Numerous authors have stressed the critical need for empowering nurses especially during the time of professional preparation as a way to reduce attrition and to maintain and upgrade professional competence (Jones & Meleis, 1993; Kramer & Schmalenberg, 1993; Schmieding, 1993; Hawkins, 1992; Chally, 1992; Wake & Coleman, 1992; Bass, 1991; & Manthey, 1989; Carlson-Catalano, 1988; Duke, 1998). However, there is a void in research that examines students' sense of empowerment at the time of graduation, or how students differ based on their educational preparation.

There has been a major change in the demographics of the student population in nursing. There is an urgent need for further research to understand nursing students' sense of empowerment, as well as the interrelationships that exist among students' backgrounds, self esteem, educational preparation and readiness for self-directed learning.
Purpose

The general purpose of this study was to examine the levels of empowerment, self-directed learning readiness and self-esteem of graduating students of two basic types of nursing educational programs. Ancillary purposes were to: (1) determine the impact of the educational process on empowerment by testing both beginning and graduating students, and (2) examine the relationship of empowerment to self-directed learning readiness, self-esteem, and selected demographic variables.

Research Questions

Based on the above purpose statement, the following research questions were addressed.

1. Does the level of empowerment, self-directed learning readiness, and self-esteem differ:
   (a) for students entering basic nursing educational programs and for those ready to graduate?
   (b) for nursing students enrolled in associate degree and baccalaureate degree programs?

2. How is the level of empowerment associated with self-directed learning readiness, self-esteem, type of nursing educational program and selected demographic variables?
Significance of the Study

This study should provide useful information for nurse educators, continuing education providers, and nurse administrators. This study may provide a foundation for decisions by nurse educators in many areas such as: (a) admission criteria to nursing programs, (b) teaching-learning strategies, and (c) selection of experiences and duration of educational programs. The results of the study may assist continuing education providers to plan programs that foster empowerment and individualize learning needs. Administrators will discover the need to clarify role expectations and to empower nurses instead of holding power over them.

This study is especially timely and appropriate as "health" itself is increasingly viewed as empowerment (Jones & Meleis, 1993). The World Health Organization (WHO) has proposed a definition of health as more than the absence of disease, focusing on the positive condition of physical, mental and social well-being. The health-illness continuum is losing support; a "health-within-illness" perspective is developing to accelerate biopsychosocial adaptation and self-actualization. Some leaders in the health field believe that only empowered professionals will be equipped to manage the collaborative process of empowering people for self-care, self-help and positive health behaviors, so that
they can maintain health and add quality to life (Gibson, 1991; Jones & Meleis, 1993).

Definition of Terms

The following are the operational definition of terms relevant to this study:

Associate degree student in nursing: Nursing students enrolled in a nursing program of two years duration, designed to develop technical graduates who are eligible to become registered nurses on graduation.

Baccalaureate degree students in nursing: Students enrolled in a four-year program who are eligible to become registered nurses on graduation. This is considered the beginning level of education to be a professional nurse.

Self-directed learning readiness: An individual's level of readiness for self-directed learning. This includes the following factors as measured by the Self-Directed Learning Readiness Scale (SDLR) developed by Guglielmino (1977): (a) love of learning, (b) self-concept as an effective learner, (c) tolerance of risk, (d) creativity, (e) view of learning as lifelong, (f) initiative in learning, (g) self-understanding, and (h) acceptance of responsibility.

Empowerment: A multivariate process of recognizing, promoting, and enhancing people's ability to meet their own needs, solve their own problems and mobilize the necessary
resources in order to feel in control of their own lives (Gibson, 1991). In this study, empowerment is both a process and an outcome represented by the measurement of six subconcepts/dimensions as measured by Vincenz's (1990) empowerment scale. They are: (a) potency, (b) independence, (c) relatedness, (d) motivation, (e) values, (f) joy of life.

Self-Esteem: The attitudes, beliefs and opinions an individual has about self as measured by Rosenberg's self-esteem scale (Rosenberg, 1989).

Assumptions

Assumptions of this study were as follows:

1. The level of empowerment, self-directed learning readiness, and self-esteem that the students experience can be measured through self-report instruments.

2. Participants have provided honest responses.

Limitations

Limitations of this study were as follows:

1. A purposeful sample of nursing students representing associate and baccalaureate programs from private and public institutions in the mid-Atlantic region was used for this study. Because the sample was not random,
it cannot be assumed that the results of the study can be
generalized.

2. Participation in this study was voluntary. Students who chose to participate may differ from those who elected not to respond.

3. Data were collected through self-report measures; therefore, they were subject to the inherent limitations of each such instrument.

Organization

Chapter one consists of an introduction, problem statement, purpose, research questions, definition of terms, and limitations. Chapter two provides a review of the literature on empowerment, its antecedents and outcomes and a conceptual framework. Chapter three describes the research design and methods to be used. Chapter four presents the results and the data analysis. Chapter five presents a summary, conclusions and recommendations.
CHAPTER II

REVIEW OF LITERATURE

The general purpose of this study was to determine the levels of empowerment, self-directed learning readiness, and self-esteem of nursing students from two basic nursing education programs. The primary focus was to determine the readiness for empowered nursing practice among graduating nursing students and their ability to persist as life-long learners and how they differed from beginning students. The secondary focus was to examine the relationship of the type of educational program, self-directed learning readiness, self-esteem and selected demographic variables to the level of empowerment.

This chapter is divided into four sections. The first section provides background information on empowerment and the variables which have been studied in relation to this concept. The second and third sections present self-directed learning and self-esteem, respectively. The last section presents social learning theory and a proposed theoretical model for the present study.

Empowerment

The concept 'empowerment' has gained great attention in the recent literature of many disciplines. Even though it was first explained in depth in community psychology (Rappaport, 1984), it has also been explored in educational
psychology, educational counseling, organizational development, religion, psychosocial rehabilitation, adult education, women's issues, and nursing and health care, to name a few. Irrespective of the discipline, empowerment generally is viewed as a positive value in American culture (Rappaport, 1987). Many strategies are being advocated to empower groups such as students, employees, and communities; however, use of the term varies both within and between disciplines.

In a concept analysis of empowerment, Gibson (1991) viewed it as a complex and multidimensional concept which is easier to be understood by its absence than by its presence. The absence of empowerment results in powerlessness, hopelessness, loss of control over life events and dependency. After studying its characteristics, antecedents, and consequences, Gibson redefined empowerment as:

... a social process of recognizing, promoting and enhancing people's abilities to meet their own needs, solve their own problems and mobilize the necessary resources in order to feel in control of their own lives. (p. 359)

Pooling the information from various disciplines, Vincenz (1990), a clinical psychologist, categorized empowerment under the three major paths of (a) individual centered, (b) interactional centered, and (c) ecological centered. The individual centered approach was developed
first in educational psychology and educational counseling where self-empowerment is seen as a systematic way of facing life and achieving happiness. Self-empowerment is considered to be self-awareness to understand powerlessness and to facilitate change through effective problem solving and decision making. A self-empowered life style is believed to promote purposeful living, self-direction, commitment, inner security and rewards, personal growth and self-satisfaction.

An interactional approach is adopted in organizational management. The goal is to empower organizations and their workers for quality work life. Within this discipline, to empower is to create power, and the means of empowering are educating, leading, structuring, mentoring, providing and actualizing. The old theme of "power as control" is replaced by "empowerment as creation" (Vincenz, 1990).

An ecological approach is adopted in community psychology, where individuals and groups in varied circumstances are empowered to enhance possibilities to gain control over their lives. Empowerment is seen as both a process and outcome, with the goal of enabling people to be in charge of their lives. That includes control in all aspects of life, such as in the political, economical, interpersonal, psychological, and spiritual state. Intrinsic to it are the values of individual determination

Vincenz (1990) developed a tool for measuring the concept of empowerment and tested its psychometric properties. She also identified empowerment as a process and an outcome having a bidirectional focus, i.e., empowerment of self as well as others. She concluded:

As a process variable, empowerment expresses a positive spirit of activism on behalf of the needs, goals and desires of the self and others. As an outcome variable, empowerment reflects mastery of one's personal life and effective involvement with one's environment, whether it be interpersonal, social, occupational, political or spiritual. (p. 32)

Vincenz (1990) identified six critical dimensions of empowerment and these are: (a) potency, (b) values, (c) relatedness, (d) motivation, (e) independence, and (f) joy of life.

The first dimension, potency, is a synthesis of the subconcepts of perceived control, a feeling of competence, initiative, assertiveness, and leadership. Potency spans the continuum from being enabled to feeling disabled. On the disabled end, individuals experience helplessness, and a feeling of failure and incapacity. The second dimension, values, is a combination of elements of respect for human dignity, cherishing the value of human diversity, volunteerism, and altruism. The continuum for values has
life affirming values on the empowered side and cynicism on the unempowered side. The third dimension, relatedness, is a synthesis of subconcepts of related capacities, i.e., help-giving and receiving, trust, collaboration, and identification with groups. Relatedness spans from involvement with other people to isolation. On the low end of empowerment are mistrust, competition and fear of people. The fourth dimension, motivation, ranges from striving to fulfill goals to resisting exertion. On the empowerment side, motivation is characterized by the ability to visualize goals, strength to mobilize effort when needed, desire for self-improvement, development of one's talents, and the commitment to follow through on decisions. On the opposite pole are lack of discipline, direction or desire to grow. The fifth dimension, independence, includes freedom from constraint, autonomy and a positive view of the self. Independence ranges from feeling free to feeling bound. The last dimension, joy of life, is a synthesis of subconcepts of happiness, quality of life and vitality. Joy of life ranges from feeling happy to feeling depressed.

Empowerment and Nursing

A number of studies have reported powerlessness among nurses and its relation to poor performance, increased attrition, and dissatisfaction with the profession (Corwin,
1961; Kramer, 1974; Ashley, 1975; Winstead-Fry, 1977; Ellis & Harly, 1984; Rosenow, 1985; Katefran, 1985; Chandler, 1992). Corwin (1961), for example, was among the first to bring to light the incongruity between professional and bureaucratic role conceptions in nursing. According to Corwin, disillusionment of new graduate nurses occurred since there was a conflict between bureaucratic health care agencies and professional values developed during their educational process. Kramer (1974) studied this conflict which she termed reality shock among new graduates when they made the transition from the ideal world of an educational institution to the real world of a bureaucratic work setting. Kramer found that nurses, being low in the hierarchical structure, lack autonomy and control over their own professional practice. Kramer also found that the reality shock experienced by new graduates led to dissatisfaction, drop out, or stagnation in the job.

Chandler's (1992) research on the sources leading to staff nurse empowerment demonstrated that 52% of the study subjects experienced powerlessness from negative interactions with physicians. In Chandler's study, staff nurses from two community hospitals and three medical centers were asked to describe an empowered situation and a powerless situation. The most empowering experience was a nurse-patient/family interaction, which gave them an inner
feeling of satisfaction and pride because their intervention/teaching made a difference in their client's coping. When patients responded with increased knowledge, independence, self-care or comfort, the nurses experienced satisfaction and empowerment. Chandler (1992) believes that this sense of connectedness has been misunderstood, trivialized and unexamined in today's medical care system.

On the other side of the coin, powerlessness in Chandler's study (1992) was described by nurses as not being recognized or appreciated, and being ignored and verbally attacked, mostly by physicians. She concluded that the harsh situations described in the negative nurse-physician interactions may result from the physician's perceptions of nurses as a threat to their control and status. The devaluations of nursing activities by physicians was supported in a study by Webster (1985) concerning medical students' perceptions of the role of the nurse. Sixty medical students were surveyed from one medical school. The results indicated that the vast majority of students (67%) assumed that nursing was essentially a lower level of medicine, entirely dependent on physician's supervision, rather than seeing nursing as a separate profession, with some overlapping areas of concern.

Winstead-Fry in 1977 related the nurses' sense of powerlessness to nursing's historical emphasis on self-
sacrifice, charitable work and obedience. She emphasized that in order to obtain the ability to practice professionally, nurses must gain expertise, authority and power. Kelly (1978) in her compelling article on the "power of powerlessness" stated that powerless nurses give rise to more powerless nurses by keeping them from achieving and accomplishing their goals.

In a study of 250 nurses from 15 hospitals in six geographically distinct cities, Prescott and Dennis (1985) found that nurses placed a low value on exertion of power to affect organizational policy. They were ignorant of the means available to them. The director of the unit was considered the determinant of the nursing department's power. Only 10% of the staff nurses knew the policy development process. Lack of information, support and resources lead to powerlessness, apathy and indifference.

Bush (1988) studied locus of control, perception of powerlessness, and job satisfaction in hospital nurses. Bush used the Rotter Internal-External Scale to determine the locus of control, the Health Care Work Powerlessness Scale to determine the perception of powerlessness, and the Job Descriptive Index to measure job satisfaction. The sample consisted of 10% of all the nurses at each of six hospitals in the area. Nurses whose basic education was BSN had lower scores for powerlessness and greater internal
locus of control. Nurses licensed prior to 1960 were less powerful than those licensed more recently. The level of powerlessness was found to be significantly more predictive of job satisfaction than locus of control.

Nursing has a unique contribution to make in the health care system. In order for them to provide the best that they are capable of, they need to be empowered. Only empowered nurses can empower their clients to gain control over their health and well being. The 1980s and 1990s have seen a heightened interest in empowerment and empowerment strategies. Many positive outcomes have been described and empirically proven (Gibson, 1991).

Kramer and Schnalenberg (1993) conducted an experimental study for a period of 5 years to determine the magnetism or the goodness of the hospital, specifically assessing the quality of nursing care. Evidence of autonomous, empowered behavior at all levels of nursing personnel was one of the critical factors they sought in magnet hospital status. At the completion of the study, the authors reported that the nurses not only gained an empowered status but exceeded the standard of magnetism in empowerment. This was clearly evident starting from the philosophy and mission statement to front line nurses at the bedside. The nurses functioned with a high level of competence and demonstrated a blending of scientific theory
and human caring. They were confident in their knowledge and assertive enough to keep others from overriding patients' wishes. Compared with nurses in nonmagnet hospitals, a significant difference in valuation and associated competence was found. The majority of nurses in the magnet hospitals were professionally qualified, held national certification and demonstrated a zest for participation in continuing education through journal clubs, quality care conferences, grand rounds, writing journal articles, participation in committee work and conducting and attending various programs. They had accepted their responsibility with pride and therefore integrated their personal and professional lives in order to constantly maintain and upgrade their competence.

Factors that helped them achieve this level of excellence were: (a) autonomy in their practice, (b) trusting and collaborative relationships with physicians and other members of the health team, and (c) an absence of an hierarchical bureaucratic administration. Nursing supervisors were like resource persons, they functioned as a cohesive group, being role models and providing valuable self-efficacy information.

Gorman and Clark (1986) conducted a 3 year, quasi-experimental study to examine how nurses applied their clinical knowledge and skills in the clinical setting, to
identify barriers to nursing practice, and to test the effectiveness some empowering strategies had in improving nursing practice. Three hundred and forty staff nurses from nine large hospitals in the New York metropolitan area and 20 expert panel members were included in the study. The expert panel included (a) directors of nursing service, (b) nurse educators, and (c) nurse researchers. The staff nurses were randomly assigned to experimental and control groups in equal numbers. With the assistance of panel members, four empowering strategies, i.e., the practice of analytic nursing, charge activities, collegiality and sponsorship, were incorporated in a series of training activities to which the experimental group of nurses were exposed. The study findings showed that nursing professionals can be in fact prepared to function more effectively, and that organizations can be designed to promote better use of these professionals. The training program included both educational and structural solutions to powerlessness as experienced by the nurses in hospital settings. The experimental groups gained a greater sense of control and became more satisfied and committed to their work in addition to scoring higher on all of the factors that were taught. The strategies used brought forth significant change in the perceptions of the nurses about themselves and their profession.
Research on power and empowerment in nursing has been more prevalent in the administration and management field. Brown and Schultz (1991) studied the level of empowerment of nurse executives in hospital settings in relation to health care outcomes under their jurisdiction. Using a qualitative method, extensive interviews were conducted to arrive at emerging themes which could be either empowering or overpowering. The empowered executives were energized, enjoyed their work, felt creative and motivated and adopted measures to empower their staff members. Overpowered executives were unable to achieve their maximum potential, felt depressed at times and had less energy for work.

Farley (1987) studied the power orientation of nurse administrators and staff nurses in 21 urban and 22 rural hospitals. Using a Power Orientation Scale, data were collected from 43 administrators and 43 staff nurses. The administrators held more positive orientations to power; they saw power as good, power as political, and power as control and autonomy than did staff nurses.

Boyle and James (1990) studied the practice of mentoring of nurses in management positions as an empowerment strategy in a large hospital. They determined that the crucial time for being mentored is early in the nurse's career. Mentoring was found to be important in teaching skills, giving feedback, and allowing the
demonstration of ability. Mentors, for most of the nurses in this study, were their superiors or their colleagues. It was also found that nurses identified their mentors as role models. Similar findings were reported by Meighan (1990), and Moore and colleagues (1988).

Independence, which is a subconcept of empowerment, was studied by Alexander (1988) who used Schutzenhofer's Professional Nursing Autonomy Scale, and Pankratz and Pankratz Nursing Autonomy and Patients' Rights Questionnaire. One hundred and thirty-two nurses from seven hospitals and 107 nurses from nine public health department completed the surveys. Variables related to perceptions of independence were education, age, gender, marital status, years since graduation and job longevity. Both hospital and public health nurses perceived client autonomy similarly. Public health nurses perceived themselves to be more independent than hospital nurses.

McCloskey (1990) looked at autonomy, a subconcept of independence, social integration and job contentment in a longitudinal study over a 16-month period with a sample of 320 nurses. Information gathered included level of autonomy, job satisfaction, organizational commitment, and intent to stay on the job. The author concluded that nurses having low autonomy and low social integration were less
satisfied, less committed, less motivated and less likely to
remain in their jobs over 6 months.

Manthey (1989) recommends a four step empowerment
process based on her study of nurses in acute care settings.
Observing the work situation of staff nurses having to
satisfy at least four "bosses," namely: (a) the nursing
supervisor, (b) the physician, (c) the patient, (d) and the
administrator, she identified the source of empowerment as
delegation of power. The four steps of the empowering
process consisted of: (a) identifying informal leaders, (b)
establishing productive groups, (c) achieving consensus in
decision making, and (d) developing a communication network.
In this study, empowerment was best derived from recognizing
the value and worth of the staff nurses as part of their
work team.

Ameigh and Billet (1992) reported caring as a key
factor in empowerment based on a hospital-wide project. In
1988, the Geisinger Medical Center formalized a caring
program based on Disney's approach to people management.
"The pixie dust formula," (training + communication + caring
= pride) served as a guide for revision of the hospital's
orientation program. The program was designed to acquaint
the new employees with the institution's founding values.
Geisinger's commitment to education and caring enhanced
self-esteem, self-confidence and autonomy among their staff.
Staff nurses showed greater commitment, stronger professional practice and a greater desire to make a difference in the quality of service provided.

Identifying empowerment as a key component of professional nursing practice, Havens and Mills (1992) studied staff nurse empowerment as part of a multidimensional study. Data was collected from staff nurses of 520 hospitals in order to indicate their ability to influence present practice and their projection for the future. The study concluded that the hospitals affiliated with colleges or universities having baccalaureate or higher education programs in nursing had implemented more features that promoted staff nurse involvement. The authors interpreted this finding as indicative of the fact that collaboration between education and practice was a key facilitator for empowerment of staff members. Educational level and clinical specialty of practice also were factors influencing staff nurses' involvement. The projection for the future was greater involvement in decision making that affect nursing care, working conditions, and the work environment.

Clark (1991) compared the level of empowerment experienced by staff nurses employed in episodic and community settings using Vincenz's empowerment scale. Using a descriptive, comparative design, data were collected from
23 matched pairs of staff nurses representing both areas of practice. The study revealed community health nurses perceived themselves to be better empowered than hospital nurses. In addition, community health nurses felt more independent from pressures to conform like in a hospital setting, scored higher on all subscales of empowerment and experienced greater satisfaction with their work life.

From these studies, it can be seen that empowerment enhances nursing practice and adds to nurses' satisfaction with work and life. Stratton (1990) added another dimension to the impact of empowerment. She explored the relationship among dimensions of a hospital organizational climate, peer culture, and empowerment of nurses and client care outcomes. One hundred and fifty-eight staff nurses employed as primary nurses in a large teaching hospital and computerized data bases of clients they cared for over a period of one year provided the data for the study. This process yielded 6,533 client records. The staff nurses completed climate description questionnaire, quality of employment survey, nurse collaborative practice scale, nurses' assertiveness inventory, measures of peer culture, and demographic data. Findings of the study showed nurse empowerment to be positively related to organizational climate. Peer culture and assertiveness, as well as peer culture and participation in decision making, were positively related. Finally, with
empowered nurses, and controlling for medical condition, highly favorable outcome measures of client well-being was identified. Clients had a shorter hospital stay, less complications, and gained independence and confidence in self-care faster.

**Empowerment and Nursing Education**

Numerous authors have emphasized the importance of empowerment in education and the means of achieving it (Chally, 1992; Dickelmann, 1990; Gibson, 1991; Green, 1988; Hawkins, 1992; Hawks, 1991; Heinrich & Witt, 1993; Watson & Revis, 1988). Pamela Chally (1992), for example, conceptualized empowerment through teaching, built on the feminist belief that successful and effective teaching is a co-intentional process emerging from meaningful connection between students and faculty. Empowerment results from teaching characterized by caring, commitment, creativity, interaction and recognition of the humanity of both teacher and students. Tools that students and teachers must possess or acquire for empowerment include positive self concept, creativity, resource information and support. This perspective, Chally explains, will permit a new understanding of teaching that results in empowerment of both parties involved in the process of learning.

Gibson (1991), in a concept analysis of empowerment, describes health as empowerment based on the World Health
Organization's definition of health. Empowering people for self care, self help and environmental improvement as well as promoting positive health behaviors is essential for maintaining health. Therefore, the nursing domain encompasses various roles as helper, support person, counselor, educator, resource consultant, resource mobilizer, facilitator, enabler and advocate. The nurse-client interaction is to include trust, empathy, participatory decision making, mutual goal setting, cooperation, collaboration, negotiation, overcoming organizational barriers, organizing, lobbying and legitimacy. Therefore, nursing education is to instill in their to-be professionals a clear vision of health and their role.

Hawks (1991) presented an educational model for empowerment of nursing students. Antecedents of empowerment primarily is a caring and nurturing environment. In order to create such an environment, there must be trust, openness, honesty, genuineness, communication and interpersonal skills, acceptance of people as they are, mutual respect, courtesy and shared vision. As a result of empowerment, the empowered person will have increased ability to reach goals. This will be evident through problem solving ability, improved communication and leadership skills, self-esteem, autonomy and responsibility.
The person will become intellectually reflective, caring and ethical and will pursue a lifetime of meaningful work and life-long learning. The line of separation between teacher and student will diminish with empowerment and the teacher will have the satisfaction of witnessing the growth of self and others.

Carlson-Catalano (1988) conducted a descriptive study to determine what nurse educators believe about their graduate's ability to practice professionally in the hospital and what empowering activities nurse educators utilize in the education of nurses. She defined empowerment as enabling nurses to practice professionally through categorized activities determined as empowering. These activities were developed based on Gorman and Clark's (1986) research. The second part of the study examined empowering behaviors of educators. Teacher behaviors for empowering students were to provide opportunities and knowledge in four areas that were identified as essential for effective nursing practice. Those four categories were: (a) analytic nursing, (b) change activities, (c) collegiality, and (d) sponsorship or ability to gain organizational know-how. Forty teacher activities were included in the study that supported the above categories. Some examples of such activities were verbal encouragement, collegial critique, role modeling, role-centered case analysis, etc. Data were
collected from nurse educators in the state of New Jersey. It was found that the nurse educators who participated in the study believed that the nursing graduates were able to practice professionally in a hospital setting. Teachers utilized only one-fourth of the empowering teacher activities listed. Doctorally-prepared educators had consistently utilized a greater percentage of items.

Fong (1992) completed a longitudinal, qualitative study over a period of eight years to identify factors that contributed to peak performance among eight nursing educators in the state of California. Peak performers were defined as those with a personal mission and commitment to excellence, capable of self-management and team building, and have the ability to change their course and manage the change well. From a convenient sample of 141 nurse educators, eight subjects were selected based on questionnaires they completed to measure role overload, social support, burnout level, and effectiveness of their work. Data were collected by tape-recorded personal interviews. These participants were rated high in independence, motivation, potency, relatedness and value of life which are all components of empowerment. They had intense commitment to a mission, were self-directed in setting goals and priorities and recognized the importance of interdependence among colleagues. The author concluded
that the most powerful and effective action for achieving peak performance is to invest in yourself.

Duke (1988) studied the relationship between leadership behaviors of the nurse education administrators and empowerment of nursing faculty and students. Nursing students, faculty and nursing school administrators from the western region participated in the study. A significant relationship was found between leadership effectiveness and the empowerment subunits concerning freedom to act intentionally and involvement in creating change.

Beck (1991) conducted a phenomenological study to find student-faculty experiences that are perceived as caring. Caring was considered a powerful distinctive attribute to nursing as well as an empowering experience to students. Caring experiences perceived by students were: (a) treating them with respect, (b) understanding their inter-dependence, (c) assisting them to grow, and (c) allowing them to become or reach their full potential. Newhall (1990) investigated the relationship between wellness behavior and personal perceptions of empowerment among baccalaureate nursing students. Sixty-eight junior and senior nursing students responded to the life style assessment questionnaire and an empowerment tool. A highly significant correlation was found between wellness behaviors and empowerment. Further analysis revealed higher power scores among senior students.
Using a descriptive design, Hobbs (1991) explored manifestations of the educational environment that foster empowerment. Power as knowing participation in change developed by Barret was used for determining empowerment. Power indicators were having choices, knowledge, freedom to act intentionally and creating change. Eighty-eight students completed the paper and pencil tool and 18 were interviewed for qualitative data. The low-scoring group reported more hindering manifestations within their educational environment than the high-scoring group. The most common hindering manifestations were limited curricular options, overly structured policies, not feeling ready to choose and faculty indifference. The most common factors identified as helpers were a structure that fosters senior year independence, feeling ready to choose and faculty attitude that support assertive behavior.

**Demographic Variables**

Demographic variables considered in this study are: (a) age, (b) gender, (c) racial/ethnic background, (d) prior educational level, (e) work experience, (f) professional and community affiliation, and (g) the program of study. Many of the investigations have combined two or more variables in their studies; consequently, the results do not easily lend themselves to categorization. Thus, this section is not
intended to be totally inclusive or exclusive, as some similar variables appear in other sections of this review.

Age

Nursing schools are witnessing a change in the demographics of nursing students which is a national trend. Age level of generic nursing students varies from 18 to 52 years with a mean age reported as 24.8 (Linares, 1989; Lengacher, 1993). No studies have been reported that looked at the relationship of age level to empowerment.

However, Alexander (1988) reported independence, as a subscale of empowerment, increased with age, education and experience for public health nurses. Age and educational level had contradicting findings in McCloskey's (1990) study of empowerment of staff nurses on a medical-surgical floor with functional assignment. It is not clear whether the monotony of the job contributed to this finding or other variables. Linares (1989) found that the level of self-directed learning readiness was higher for older students.

Gender

Nursing is predominantly a female-dominated profession and, therefore, it is greatly influenced by the status awarded to women in society. Even though men account for only a small percentage of the workforce, they fill a disproportionately high percentage of senior posts (Dolan,
1993). Thus, gender has a major impact on nursing as a profession as well as within the profession.

Literature in general, as well as in nursing, is replete with the oppressive state of women (Mason, Backer, & Georges, 1986; Kramer, 1993; Sohier, 1992; Heinrich, 1993; Sapiro, 1983; Roberts, 1983; Vance, et al., 1985; Watson, 1988). Status and power relations between groups are an important part of the problems facing nursing professions. Raising consciousness of their oppressive state and establishing positive relationships, thereby promoting their level of empowerment has been reported as a way to enhance progress.

Ellis and Hartly (1984) found that the powerlessness of nurses in the health care system was related to the fact they were women and lacked knowledge to gain power. This idea was supported by Prescott and Dennis (1985).

Rosabeth Kanter (1977) conducted a study entitled "Men and Women of the Corporation" which brought to light organizational concepts which may be applied to nursing in the hospital setting. The purpose of this study was to examine ways in which organizational structures provide the context for developing one's sense of self and one's possibilities. Power was seen as the ability to mobilize resources to get the job done. It was interesting to note that Kanter found that the problems of women in the corporation were related to powerlessness.
Using a combination of both qualitative and quantitative techniques, Katznian (1985) investigated the transition from the traditional role of the nurse to an expanded role. The study subjects were staff nurses, nurse practitioners and physicians. Findings suggested that both nurse practitioners and staff nurses in the traditional roles reported egalitarian attitudes but displayed submissive behaviors toward physicians. The subjects' perceptions of domestic and professional roles for women were significantly related, but differed in rank order as nurse practitioners being most egalitarian and physicians being most traditional. The author concluded that in spite of pressure on society to change, subordination of female nurses still exists and this subordination is influenced by the stereotypical male-female roles learned in the family.

Racial/Ethnic Background

The majority of the nursing students continue to be from the mainstream population. Recent trend indicates an increase in the minority representation as well as international students. Ethnic representation reported in some of the recent studies of generic nursing students were as follows: (a) white, 82-84%; (b) African-American, 8-10%; and (c) Hispanic, 5-8% (Lengaeher, 1993; Linares, 1989).

Munro (1980) observed that ethnicity was highly related to aptitude, locus of control, social integration, and
persistence in higher education in nursing. Linares (1989) observed similar findings in her study. White students were more internal in their locus of control orientation than black and Hispanic students. Attrition rate was higher for minority students and their readiness for self-directed learning was low. Zimmerman (1992), in an empowerment study where white and African-Americans were represented, observed low involvement and lower self-efficacy among African-Americans. However, when the two groups were compared among those who were involved in community participation, African-Americans scored higher on one's sense of control than white participants.

Importance of empowerment to overcome failure and oppression among minority students and communities has been documented extensively in the literature (Cummins, 1986; Davis, 1988). Cummins (1986) developed a strategy for empowering minority students by validating their cultural values by the school curriculum. The experimental group that were exclusively Spanish speaking excelled in both English and Spanish by the end of the year.

Empowered education applied to health also has shown remarkable success as shown by Wallerstein (1988). In this ethnographic study, Indian and Hispanic adolescents were brought into hospitals for dialogue on prevention of
substance abuse and transformed them into empowered individuals who were in control of their lives.

Educational Background

Traditionally, nursing students entered the nursing program after their high school education. Presently, as with age level, a wide variation is expected with an increase in nontraditional students (Gruca, 1994). There have been no studies reported indicating whether any relationship exists between educational level and empowerment. However, self-directed learning readiness has been noted to increase with educational level (Linaro, 1989; Sabbaghian, 1979).

Work Experience and Community Involvement

Zimmerman (1992) found a positive relationship between participation in community organizations and empowerment. A sense of competence and critical awareness of the sociopolitical environment facilitated this process. This finding was supported by Kieffer (1984) who conducted in-depth interviews with 15 individuals who emerged as leaders in community organizations. He concluded that the skills necessary to participate effectively enhances self-esteem and a sense of perceived efficacy.

Rubini (1988) studied the effects of work and educational variables to reformism scale. The reformism scale measured the extent to which respondents believed in
the need for a health care reform. Subjects were 1,434 nursing students in the state of California. Students with a baccalaureate degree or higher and those with work experience outside the hospital, scored higher than those who worked in a hospital setting with lower levels of education.

Self-Directed Learning Readiness

Self-directed learning readiness has gained considerable attention in continuing professional education as well as in basic nursing education. However, adult education literature has dealt with this topic in greater depth than any other discipline. There have been some concerns raised due to a lack of a unified, comprehensive understanding of what self-directed learning is (Brockett, 1983; Brookfield, 1984; Candy, 1991; Brockett & Hiemstra, 1991). This is because of the earlier conception of it being a process of self instruction.

Guglielmino (1977) described a highly self-directed learner based on her survey of expert as one who possess initiative, independence and persistence in learning and accepts responsibility for developing and completing goal-oriented learning tasks. They also have a strong desire to learn; possess basic study skills and are self-confident in facing the challenges and obstacles. A self-directed
learning readiness scale (SDLRS) was developed by Guglielmino as part of her doctoral study. It was designed to assess the extent to which individuals perceive themselves to possess skills and attitude associated with self-directedness in learning.

Houle (1980) noted that a life time of learning is required for maintaining professional competence and this learning must be self-directed. Therefore when they complete the formal education, professionals should have the readiness to continue to learn. The three modes of learning identified in Houle's (1980) conceptual model are: instruction, inquiry, and performance. This model was supported by the studies conducted by Gibbons (1980) and Corvero (1983).

Tough conducted the earliest research in self-directed learning in 1966 in a study entitled "Adult as Self-Teachers" (Tough, 1979). This initiated numerous studies as well as critiques and articles in adult education literature. Tough, in this study, focused on individuals engaged in self-teaching projects. It was found that the typical adult had spent time in about eight learning projects during the year. Major reasons for the study included preparation for job or maintaining job skills. Most learning projects were motivated by some anticipated
use or application which is in line with adult education theory.

Torrance Mourad (1978) administered an abbreviated version of the SDLRS to students who ranged from grade 3 to grade 12 and were participating in programs in 24 states for students identified as gifted. The self evaluations of self-directed learning was high for gifted students. In addition, there was a significant correlation between SDLRS scores and grade level. They were able to provide construct validity of the instrument. Forty-one graduate students completed the scale. Findings suggested that creative experience and achievements associated with the right brain hemisphere style of learning and thinking.

Sabbaghian (1979) conducted a study to describe and analyze characteristics of persons who were self-directed in learning. The population for the study was 77 adult students enrolled in Iowa State University. A close positive relationship ($r = 0.558$) was found between adults' self-directedness in learning and their self-concepts. Freshman adult students were less self-directed as compared to senior students. Individuals with more formal education demonstrated higher self-direction in learning. This was also true for those with higher grade-point averages. However, age and gender by themselves, were not significantly related to self-directed learning readiness or
self-concept. Sabbaghian concluded that as adults gain ability to be self-directed in learning, they also perceive themselves to be worthy individuals in every aspect of life.

Hassan (1982) studied 77 adults randomly selected from the population in Iowa to compare individuals' perceptions of self-direction and actual participation in learning projects. Data were collected through interview and self-directed learning readiness scale (SDLRS). Significant positive relationship was found between the number of learning projects and their level of self-directed learning readiness.

Based on a sample of 65 professional staff from Iowa State University Cooperative Extension Service, Hall-Johnsen (1986) found a positive predictive relationship between readiness and number of self-planned projects conducted, as well as the amount of time spent in study projects. Skaggs (1981) studied self-directed learning readiness, locus of control including biographical information of staff nurses in Texas. She found a significant relationship between SDLRS scores and the number of hours devoted to self-directed learning activities. Skaggs found self-directedness to be related to internal locus of control and negatively related to influence by powerful others such as supervisors.
Brockett (1985) looked at the relationship between self-directed learning readiness and life satisfaction of 64 older adults. A statistically significant positive relationship was found between life satisfaction and their self-directed learning readiness. Although age did not significantly correlate with either variable, a significant positive correlation was found between self-directed learning readiness and their formal educational level.

Guglielmino, Guglielmino, and Long (1987) in a study of 753 individuals employed by a large utility company found a significant relationship between self-directed learning readiness and above average performance appraisal. The mean score was significantly high for those holding high level job demanding frequent change and problem solving skills.

Rosenberg (1989) conducted an ethnographic study with the assumption that if students are to be active reflective learners, the teacher should serve as a mediator for helping students. He concluded that teachers helping students to become independent learners in college classrooms should consider the dialectical nature of the learner-student relationship in which teacher's authority changes and students evolve.

The importance of continuing life-long learning is an enduring theme in nursing literature. Although self-directed learning is not a new phenomenon among nurses,
there has been an increasing interest and recognition of self-directed learning as an integral component of continuing professional education as well as basic nursing education. Certain commonalities emerged from the studies of self-directed learning readiness (SDLR) involving nurses or nursing students (Alspach, 1991; Box, 1982; Echols et al, 1992, 1994; Good, 1985; Palumbo, 1989; Savoie, 1980; Wiley, 1983).

Savoie (1980) investigated the possibility of predicting success in continuing education by the use of SDLR scale. One hundred and fifty-two nurses enrolled in continuing education courses served as the sample for the study. A positive relationship was found between SDLRS score and course grades, and self-concept of the participants. It was concluded that SDLRS score can be useful in providing assistance to those in need for extra support to succeed in their learning experience.

Wiley (1983) conducted an experimental study, by providing a 12-hour "process-oriented," self-learning project as the treatment for the control group. A total of 85 nursing students participated in the study. The pretest-posttest comparison revealed no change in SDLRS score. These students who preferred low structure gained in SDL readiness when they had the opportunity to experience SDL. Those needing more structure in learning had a decrease in
SDLRS score. The study concluded that SDL projects are not beneficial for all students unless they experience self-directed learning readiness.

Box (1982) investigated the differences among three levels of nursing students in the associate degree program. Based on the data collected from 477 nursing students, no significant differences were found in their SDLRS scores. The students' grade-point average correlated with their SDLRS scores as reported by Savoie earlier.

Crook (1985) explored the predictive validity of SDLRS by obtaining the data from 63 first year nursing students in the beginning of the academic year. At the end of the year, the students were asked to select three self-directed learners from their class. A significant correlation was found between peer nomination and course grade.

Palumbo (1989) measured change in SDLRS scores over time among registered nurses studying for a baccalaureate degree. After a period of one and a half years, the 45 nurses under study showed an increase in SDLR scores.

Alspach (1991) conducted a descriptive, comparative study using SDLRS to identify the level of self-directed learning readiness among baccalaureate degree students and the factors that influence this readiness. A total of 357 senior nursing students and 86 faculty members participated in the study. Mean score of SDLR for both students and
faculty were above average, but faculty scored significantly higher than students. There was a significant difference in SDLR scores based on the type of nursing student. Students with a baccalaureate degree in a nonnursing field had significantly higher SDLRS scores than either traditional or generic students. Students' gender, marital status, and prior instruction in SDL projects had no relationship to their SDLR scores. But their age and cumulative grade-point average were positively associated with SDLRS score. The study concluded that the nursing programs under study provided only a limited amount of self-directed learning opportunities for students, even though the faculty's perception of providing such experiences was higher than that of the students.

Echols, Armstrong and Rustia (1992) explored the relationship among empowerment, self-directed learning readiness, sense of coherence, age and educational level of registered nurses in the midwest. The same study was replicated in the Washington D.C. area by Echols and Armstrong (1994). A significant positive relationship was observed in both studies between self-directed learning readiness and a sense of coherence and educational levels.

**Self-Esteem**

Rosenberg (1989) described self-esteem as the positive or negative attitude an individual has toward self. It is
seeing oneself genuinely worthwhile, or as having a strong ego. Virtually all prior research support the idea that high self-esteem is a valuable asset. Individuals with high self-esteem are goal directed and untroubled by self-doubt (Coopersmith, 1987).

Self-esteem is directly related to one's sense of self-efficacy and therefore empowerment (Zimmerman, 1992). Individuals with poor self-esteem are likely to feel that they have little personal control over life events and low levels of aspiration and motivation. Friere (1970) notes that oppressed groups tend to internalize their oppressor's view leading to self-deprecation.

Self-esteem is critical if one is to become empowered (Sapiro, 1983; Chally, 1992). Self-esteem develops through a variety of experiences and relationships. A basic belief in the worth and dignity of all human beings must be the basis of relationships if self-esteem is to be fostered (Chally, 1992). Those who feel positive about themselves are better equipped to meet the needs of others. This is applicable to all helping relations, such as, parent-child, teacher-student, or nurse-patient.

Nursing has been described as an oppressed group because of its history (Mason, et al., 1991). Lack of unity, collegiality in addition to poor performance, dissatisfaction and exodus from nursing are all attributed
to low self-esteem of nurses. When nurses are empowered, they will expect themselves to perform at a higher level, will see the benefits of empowered care to patients and will be more satisfied professionally (Kramer & Schmalenberg, 1993).

The issues that face nursing are not isolated phenomena warns Muff (1982). They should be viewed within the context of women's issues as approximately 97% of nurses are women. The traditional socialization of women to be passive and dependent lead to low self-esteem and achievement related difficulties. Women with high self-esteem are likely to achieve educationally and acquire higher occupational status. This relationship works in reverse as well. Higher accomplishments creates higher self-esteem (Muff, 1982).

Johnson (1989) found self-esteem correlated highly with higher status in the job when nurse executives were compared with staff nurses. In addition, high self-esteem had great influence on what they sought to attain and the level of job complexity.

Witnessing a change in nursing students' characteristics, Lengacher (1993) conducted a comparative analysis of role strain and self-esteem across three academic programs in nursing. All three groups showed an increase in self-esteem from entrance to exit. Associate,
baccalaureate and LPN students differed in their levels of self-esteem.

Cronin (1987) studied self-esteem levels among three groups of nursing students from different schools. Self-esteem scores were lowest in 2-year community college students and highest for students from a large public university. Scores for students attending 4-year private colleges were in the middle of the above two schools.

Many studies have shown that nursing students have low self-esteem (Burgess, 1980; Ellis, 1980). Kelly (1993) points out that low self-esteem is closely associated with punitive instructional styles of the socialization process. Senior nursing students, in Kelly's study, felt powerless and guilty for not being able to stand up for their clients.

Ellis (1980) investigated levels of self concept of nursing students based on the assumption that advances in education also increase their sense of self esteem. The results of the study indicated that the self-esteem level was highest at the beginning of the sophomore year and lowest at the beginning of the senior year. However, how true this finding is today is unclear. Charging nurse educators and administrators to empower nurses, Mason (1991) presents three elements for empowerment in nursing. They are: (a) efforts to enhance positive self-esteem, (b) raising consciousness of sociopolitical realities, and (c)
political skills needed to negotiate and change the health care system.

In summary, there is a vast amount of literature dealing with problems of nurses as they work to remain in nursing as productive practitioners and life-long learners. Many efforts have been introduced to remedy the problem at the professional practice level. One of the major problems identified is powerlessness. In addition, low self-esteem and variation in self-directed learning readiness also are evident. There is increasing concern about nurses whose training is obsolete.

Empowerment has gained increasing attention at all levels of nursing. Many conceptual models and methods have been presented but very few have been supported by research to indicate their effectiveness.

Theoretical Framework

This study is grounded in the self-efficacy perspective of social learning theory espoused by Bandura (1979). Self-efficacy is the conviction that one can successfully execute behaviors required to produce certain outcomes. Empowerment is the expectancy belief or motivational state which is internal to the individual. According to self-efficacy theory, human behavior is a continuous reciprocal interaction between behavioral, cognitive and environmental
influences. Knowledge and skills are necessary but insufficient for accomplished performances. Self-referent thought mediates the relationship between knowledge and action. When faced with difficulties, individuals with low self-efficacy experience serious doubts about their capabilities and reduce their efforts or give up all together, whereas those who have a strong sense of efficacy exert greater effort to master the challenges. Self-efficacy also accounts for coping behavior, achievement strivings, career pursuits and self actualization (Bandura, 1982).

As a process, empowerment is enhancing the individual's belief in their self-efficacy, thereby attaining mastery and control over their lives and a critical understanding of their environment. To empower is to strengthen this belief or weaken one's belief in personal powerlessness. In order to be effective in enhancing self-efficacy among individuals, Bandura (1977) advocates providing four information sources and they are: (a) inactive attainment, (b) emotional arousal, (c) verbal persuasion, and (d) vicarious experience. Inactive attainment refers to mastering the knowledge and skills related to the job. This is similar to the popular saying "Knowledge is power." Vicarious experiences involve observing and learning from role models. Verbal persuasion is pointing out the
strengths and providing encouragement. Finally, emotional arousal indicates that negative emotions like anger, fear, and anxiety can lower the sense of efficacy. A supportive trusting environment can be more effective in strengthening self-efficacy.

Based on social learning theory the following conceptual model is proposed for this study (see Figure 1). Empowerment is closely related to self-directed learning readiness and self-esteem. Empowered individuals with their abilities and persistence would be able to realize their fullest potential.

Summary

In this chapter, the literature relevant to empowerment of nursing students has been reviewed. Problems resulting in low levels of empowerment have been addressed. Self-directed learning readiness and self-esteem and their relation to empowerment have been addressed. In the next chapter, the methods used in carrying out the study is detailed.
PROPOSED CONCEPTUAL MODEL

SDLR = Self-directed learning readiness
SE   = Self-esteem
EMP  = Empowerment
CHAPTER III

METHOD

The general purpose of this study was to determine the level of empowerment perceived among nursing students from both Associate Degree in Nursing (ADN) and Baccalaureate Degree in Nursing (BSN) programs just prior to graduation and the relationship of empowerment to selected variables. These selected variables were self-directed learning readiness, self-esteem and demographic variables such as age, gender, educational background, work experience, and affiliation with professional or community organizations. In order to examine the impact nursing educational process has on empowerment, both beginning and senior students from both programs were studied.

This chapter describes the following: (a) the research design, (b) the population and sample, (c) the instruments, (d) the procedure for data collection, and (e) statistical analysis of this study.

Research Design

For this exploratory study, a descriptive comparative design was used. Educational programs vary in their duration and emphasis even though there is no differentiation in their certifying examination or job assignment on graduation. Therefore, both ADN and BSN
students were studied. In order to examine the potential influence educational process has in fostering empowerment in basic nursing students, a cross sectional comparison of freshman and senior students was also included in the study.

The main independent factors were the type of nursing educational program (ADN and BSN) along with class levels (freshman and senior). Additionally, both variables were crossed with type of institution (public and private). See Figure 2 for the design. The type of institution was included for sample selection purposes. Because preliminary analyses indicated no difference between private and public schools within the respective programs, this variable was excluded from the design for the analyses of interest.

Population and Sample

Institutions that provide basic nursing education such as ADN and BSN programs in the mid-Atlantic region provided the setting for the study. ADN and BSN programs prepare graduates to become registered nurses. The type of institutions that provide nursing education to prepare registered nurses in the Washington Metropolitan Area fall into three categories: private and public universities and community colleges. Private institutions claim to have fewer students in classes, and therefore, greater individual attention is given to students according to their mission statement.
<table>
<thead>
<tr>
<th>Programs</th>
<th>Level of Students</th>
<th>Private</th>
<th>Public</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADN</td>
<td>Beginning</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Graduating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BSN</td>
<td>Beginning</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Graduating</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 2
Design for the Study
Community colleges provide ADN programs only. Therefore, at least one private and one public university providing BSN program and one private university and a community college providing ADN program were selected based on their willingness to participate in this study. All nursing schools were accredited by the State Board of Nursing and National League of Nursing. This accrediting process ensures all schools meet minimum standards or better according to the standards established by those controlling bodies. Each nursing school enrolls between 20-100 undergraduates annually. Both beginning and graduating classes were included in the study.

The sample selected was one of convenience rather than random. However, there is no reason to suspect that the students attending these universities are markedly different from individuals attending private or public institutions in any other larger metropolitan area.

One of the major problems inherent with survey research is low response rates. With group administration of questionnaires in the class, a higher percentage of response was achieved. All ethical issues associated with survey research were taken into account.
Instruments

Four instruments were used in this study. Independent variables were measured by a personal data sheet. Dependent variables were measured by Vincenz empowerment scale (1990), self-directed learning readiness scale (Guglielmino, 1977) and Rosenberg's self esteem inventory (Rosenberg, 1989).

Vincenz Empowerment Scale (VES)

This scale was developed by Vincenz (1990) to measure individuals' perceived level of empowerment. This 74-item self-report inventory, using a 5-point Likert format, has six subscales measuring six dimensions of empowerment (see Appendix A). The subscales, with an explanatory item from the scale, are as follows: (a) Potency--I AM ENABLED VS. I AM DISABLED, (b) Independence--I FEEL FREE VS. I FEEL BOUND, (c) Relatedness--I AM INVOLVED WITH PEOPLE VS. I AM ISOLATED, (d) Motivation--I STRIVE TO FULFILL MY GOALS VS. I RESIST EXERTION, (e) Values--I HAVE LIFE-AFFIRMING VALUES VS. I AM CYNICAL, and (f) Joy of Life--I AM HAPPY VS. I AM DEPRESSED.

Reliability. Reliability has been assessed for each of the subscales using Cronbach's alpha. Scores ranged from a low of 0.62 for value of life to a high of 0.82 for motivation. Overall reliability was assessed as 0.93-0.95 (Vincenz, 1990).
Validity. Construct and convergent validity were supported by the results of Vincenz's (1990) study of three groups: school board members, community residents and depressed clients. Construct validity was examined by a comparison of the scores of a known empowered group (school board members) with those of a known unempowered group (depressed clients). The VES was thus able to distinguish between those two groups. Construct validity was supported by another study done on community health nurses (Clark, 1991).

Vincenz (1990) examined convergent validity by comparing VES scores to scores on the Psychological Empowerment Scale (PES) and the Internal Control Scale (ICS). The PES is a 17-item-scale using a 7-point Likert format developed by Zimmerman and Zahniser (cited in Vincenz 1990) which has two subscales: Leadership confidence and policy control. The interval control scale is one of three subscales developed by Levenson (cited in Vincenz 1990) and utilizes items on a 6-point Likert scale related to personal competence in planning, and to being rewarded for one's work. There were significant positive correlations between PES and VES ($r = 0.80$) and ICS to VES ($r = 0.49$).

Self-Directed Learning Readiness Scale (SDLRS)

This scale was developed by Guglielmino (1977) as a self-report instrument to assess self-directed learning
readiness. The scale consists of 58 Likert-type items stated both in positive form, as well as reverse phrased items. Agreement with positive items and disagreement with reverse phrased items corresponds to readiness for self-directed learning.

The content of the scale was developed by review of literature, survey of experts, and factor analysis. The literature was surveyed to identify the characteristics that were believed to be important in self-directed learners. A panel of 14 leading experts in the field of adult education participated in a three-round modified delphi survey. In this survey they were asked to name and rate characteristics they considered to be important for self-direction in learning, including abilities, attitudes, and personality characteristics. The scale was then administered to 307 subjects in three separate geographic locations in the United States, using item and factor analysis to select items for revision. The final items were representative of the following subscales: (a) love of learning, (b) self-concept as an effective learner, (c) tolerance of risk, (d) creativity, (e) view of learning as lifelong, (f) initiative in learning, (g) self-understanding, and (h) acceptance of responsibility. Only the total score was used in this study because of the author's recommendation.
Reliability and Validity. Guglielmino (1977) reported a reliability rating of 0.87 for the SDLRS. Many researchers have used SDLRS to study self-directed learning readiness on a variety of subjects in a variety of settings and judged it to be a valid and reliable tool (Guglielmino, 1989; Long, 1989; McCune, 1989). Although others such as Field (1989) have questioned its validity and reliability, his own conclusion was that "to date, the only widely accepted means of quantifying an individual's readiness for self-directed learning is SDLRS developed by Guglielmino in 1977" (p. 125). Field's data yielded a 0.89 reliability estimate on Crobach's alpha. SDLRS has been used by more than 200 organizations around the world, and has been translated into six languages. The latest reliability estimate of SDLRS, based on a split-half Pearson product moment correlation with Spearman-Brown Correction is 0.94. The sample for the study consisted of 3,151 individuals from a wide variety of settings throughout the United States (Guglielmino & Guglielmino, 1991). At least 17 studies have been conducted specifically to examine the validity of SDLRS and a recent meta-analysis of 29 studies using the scale provides further evidence of its validity (Guglielmino, 1988). This scale can be found in Appendix B.
Self-Esteem Inventory (SE)

Created by Rosenberg (1989), self-esteem inventory is a 10-item unidimensional scale that is easy to administer and can be completed in 3-5 minutes. This instrument measures the attitudes, beliefs and opinions an individual has about self. An individual with high self-esteem sees self as good whereas those with low self esteem holds self in contempt, and are discontented. Scoring the scale involves adding the numbers selected on a 4-point Likert scale where a choice of 1 indicates strong agreement and a choice of 4 indicates strong disagreement. Five items were recoded so that for the total scores obtained, a high score indicates high self-esteem and a low score indicates low self-esteem.

This instrument correlates significantly with the Coopersmith Self Esteem Inventory (Corcoran & Fisher, 1987). Rosenberg further reports a reliability coefficient of .92 and a test retest reliability of .85 and .88. The instrument can be found in Appendix C.

Demographic Data

Designed for this study, this part of the questionnaire was to collect demographic information. Items asked for were age, gender, educational and ethnic background, duration of work experience, employment status (employed/unemployed), and professional affiliation (see Appendix D).
Procedures

Written permission to use the three research instruments were obtained from the respective authors, Vincenz, Guglielmino and Rosenberg. A copy of the research proposal was submitted to the research committee of the schools of nursing and their approval obtained.

Data collection was projected for the summer semester, 1994. To reduce the impact of extraneous variables, questionnaires were to be distributed during the midsemester when responses would be least affected by the settling-in period of early semester or the final examination tension of the end of the semester. Questionnaires were distributed through the School of Nursing to students, as a group at the end or beginning of a class, with stamped envelopes to mail the completed questionnaire or collected through their class teacher. Follow-up contacts were made by meeting with them weekly for those weeks to encourage completion and return of the questionnaire. Stamped preaddressed envelopes were provided for those who chose to mail the questionnaire. Because the investigator had an opportunity to address the class and distribute the questionnaires as a package, a high response rate was anticipated.

Confidentiality was maintained throughout the data collection process. An introductory letter was distributed in addition to a presentation and students were given an
opportunity to ask questions. Those students who were willing to participate completed and returned an informed consent form. The time required for completion of all four questionnaires was approximately 30 minutes. Participants were urged to complete and return them within one week. Each form had an assigned number that identified the institution, level and the individual. This information was available only to the investigator. No names appeared on the study instruments. All data are presented as group trends and individuals cannot be identified.

Data Analysis

The results of the study provided a profile of nursing students from five schools of nursing undergoing two types of basic educational programs in nursing. The information obtained included: (a) the level of empowerment, (b) self-directed learning readiness, (c) self-esteem levels, and (d) demographic data. Preliminary analyses of the demographic information were accomplished using descriptive statistics. In addition, analyses of variance to compare public and private schools were used for all variables to ensure that they did not differ and therefore, the type of institution could be ignored in further analysis.

Two-way analyses of variance (ANOVA) were used to determine differences in empowerment, self-directed learning
readiness (SDLRS) and self-esteem (SE) for degree programs (ADN and BSN) and class (Freshman and Senior) levels.

In order to examine the relationship of empowerment to SDLRS, SE, and demographic variables, as well as to program and level, regression was used. Because this was an exploratory study and there does not appear to be any theoretical basis for determining a specific sequence for entering these variables into the equation, a stepwise strategy for entering these variables was used initially. As anticipated these analyses provided the information as to which independent variable(s) explained the variance in the dependent variable (empowerment) as well as the strength of each independent variable in predicting nursing students' level of empowerment. Based on the results of ANOVA, stepwise regression and prior theory, an attempt was made to develop a hierarchical ordering of variables. The level of significance was set at .05.

Even though gender of the subjects was included in the data collection, it was unclear at that time the number of male students in those classes. This variable was included in the study as 12 percent of the study sample were male students. Data analysis was done using the statistical package for social sciences (SPSS).
CHAPTER IV

RESULTS

The general purpose of this study was to determine the level of empowerment among nursing students of two basic nursing educational programs and the relationship of empowerment to selected variables. Those selected variables were self-directed learning readiness, self-esteem and demographic variables such as age, gender, educational and ethnic background, present work status, work experience and affiliation with professional or community organizations. For this exploratory study, a descriptive comparative design was used. Instruments used for survey were Vincenz Empowerment Scale (VES), Self-Directed Learning Readiness Scale (SDLRS), a Self-Esteem scale (SE) and a demographic sheet. Descriptive statistics, correlation, analysis of variance and regression were used to analyze the data. This chapter presents the results of the data analysis. All statistical procedures were performed using the statistical package for the social sciences (SPSS).

Participants

Data were collected from five institutions in the mid-Atlantic region that provided associate and baccalaureate degree programs in nursing. They represented private and
public universities and community colleges. Questionnaires were distributed to all students above age 18, who were in the beginning and the graduating classes. Data were collected during the months of June to September 1994.

Out of the 323 questionnaires distributed, 294 were returned for an overall response rate of 91.02%. The return rate for questionnaires administered and collected directly by the investigator was 100% (n = 177). This included the graduating classes of two ADN schools and two BSN schools, and freshman classes of one ADN and one BSN school. The return rate for questionnaires received later through class teacher or by mail was 80% (see Table 1).

Of the 294 usable questionnaires returned, 62% (n = 181) were from private institutions and 38% (n = 113) were from public institutions. As shown in Table 2, 171 responses (58%) were from associate degree students (ADN) and 123 (42%) were from baccalaureate (BSN) students. There were approximately equal numbers (49% and 50%) of freshman students and those in the graduating class. Of 171 ADN students who responded, 81 were freshman (47%) and 90 were graduating students (53%). Among the 123 BSN students, 64 (52%) were freshman and 59 (48%) were graduating seniors.
Table 1
Response Rate and Distribution of Subjects

<table>
<thead>
<tr>
<th>Distribution: Method</th>
<th>Number Distributed</th>
<th>Number Returned</th>
<th>Percent Returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Returned directly to the investigator</td>
<td>177</td>
<td>177</td>
<td>100.00</td>
</tr>
<tr>
<td>Returned later through class teacher or by mail</td>
<td>146</td>
<td>117</td>
<td>80.13</td>
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<table>
<thead>
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<th>Distribution: Subject Group</th>
<th>Number Distributed</th>
<th>Number Returned</th>
<th>Percent Returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private School: ADN</td>
<td>94</td>
<td>94</td>
<td>100.00</td>
</tr>
<tr>
<td>Public School: ADN</td>
<td>77</td>
<td>77</td>
<td>100.00</td>
</tr>
<tr>
<td>Private School: BSN</td>
<td>112</td>
<td>87</td>
<td>77.67</td>
</tr>
<tr>
<td>Public School: BSN</td>
<td>40</td>
<td>36</td>
<td>90.00</td>
</tr>
</tbody>
</table>

Total 323 294 91.02

ADN: Associate Degree Nursing Students
BSN: Baccalaureate Degree Nursing Students
Table 2
Distribution of Participants According to the Type of Institution, Level and Program Study

<table>
<thead>
<tr>
<th>Type of Institution</th>
<th>ADN</th>
<th>BSN</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td>94</td>
<td>87</td>
<td>181</td>
</tr>
<tr>
<td>(52%)</td>
<td>(48%)</td>
<td></td>
<td>(62%)</td>
</tr>
<tr>
<td>Public</td>
<td>77</td>
<td>36</td>
<td>113</td>
</tr>
<tr>
<td>(68%)</td>
<td>(32%)</td>
<td></td>
<td>(38%)</td>
</tr>
<tr>
<td>Level in the Program</td>
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<td></td>
<td></td>
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<td>(49%)</td>
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<td>59</td>
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<tr>
<td>(60%)</td>
<td>(40%)</td>
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<td>(51%)</td>
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</table>
Characteristics of Respondents

Demographic characteristics of participants revealed this sample of nursing students to be a heterogeneous population, which is typical of nursing schools at this time. Age range of respondents varied from 18 to 60 years (see Figure 3). Adult students formed the majority overall. The average age was 27.7 years with a standard deviation of 7.6. But, across programs, 90% of the students in the associate program were adult students, whereas the baccalaureate group had only 48% (see Table 3).

In this sample, 12% (N = 35) of the participants were male students which is slightly higher than the national norm of two percent. In spite of the small number of male students, it was decided to keep this variable, as gender role expectations may have an influence on the empowerment level.

As shown in Table 3, the majority (59%) of the participants were non-Hispanic white Americans and 19% comprised non-Hispanic African-Americans who were the largest minority group. Among the other minority students, 5% were Asians, 1% Hispanics, 1% Hispanic African Americans, 1% American Indians and 12.6% stated as "other" were of African, middle eastern or East Indian origin.
Figure 3
Age of Participants in Years
Table 3
DEMOGRAPHIC CHARACTERISTICS

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<th>CHARACTERISTICS</th>
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<th>BSN</th>
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<tr>
<td>18–21</td>
<td>18</td>
<td>10%</td>
<td>59</td>
<td>48%</td>
<td>77</td>
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<td>22–30</td>
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<td>31–41</td>
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<td>42–60</td>
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<td>10%</td>
<td>5</td>
<td>4%</td>
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<td>7%</td>
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<tr>
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<td>12</td>
<td>10%</td>
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<td>African American (Non Hispanic)</td>
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<td>56</td>
<td>19%</td>
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<tr>
<td>African American (Hispanic)</td>
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<td>2%</td>
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<td>Asian</td>
<td>6</td>
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<td>0%</td>
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<td>1%</td>
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<tr>
<td>Other (majority African)</td>
<td>16</td>
<td>9%</td>
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<td>17%</td>
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<td>13%</td>
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<td>SSN %</td>
<td>TOTAL NO</td>
<td>TOTAL %</td>
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<td>Employed part time</td>
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<td>135</td>
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<td>Member</td>
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<td>15</td>
<td>76</td>
<td>26%</td>
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<tr>
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<td>108</td>
<td>218</td>
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<td>With affiliation</td>
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<td>27</td>
<td>61</td>
<td>21%</td>
<td></td>
<td></td>
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<tr>
<td>Non affiliation</td>
<td>137</td>
<td>96</td>
<td>233</td>
<td>79%</td>
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</table>
Educational background prior to entry into nursing varied from high school to post-graduate level. While half (50%) of the BSN students were just out of high school, that group for the ADN program was only 19%. This is a new trend, as a greater number of nontraditional students are choosing shorter programs. Thirty-two percent of the participants had some college credits and a slightly smaller number (28%) had baccalaureate degree or higher in nonnursing disciplines. Distributions of educational levels are also illustrated in Figure 4. A small group (6.5%) was identified as having "other" for their educational level. These consisted mostly of technical diplomas in areas such as practical nursing, clinical pathology, paramedic, computer programming, or secretarial.

A majority of the participants worked at least part time as they continued with their nursing education, with 46% employed part-time and an additional 13% holding a full-time job. Those not employed comprised 41%, which was fairly equal for both programs.

Of the 294 students who participated in this study, all but 18 of them have had some type of work experience. Approximately half (47%) of the participants noted having work experience in a hospital setting as volunteers, practical nurses, nursing assistants, laboratory technicians or administrators. Years of experience ranged from 1 to 24
Figure 4
Education Prior to Nursing
(mean 3.7, SD 4.3). Another 47% of the participants reported having health-related experiences outside of the hospital setting which ranged from 1 to 18 years (mean 3.2, SD 2.9). Such work experiences included home health care, paramedic and public health positions. Jobs listed under "other" category were teaching, office management, research assistants, the computer programmer, administration, military, life guard and babysitting. Years of experience ranged from 1 to 27 (mean 6.3, SD 5.2). Many had work experience in more than one area.

Twenty-six percent of the students were members of the Student Nurse's Association, and another 21% of the sample were actively involved in community organizations such as YWCA/YMCA, church groups, etc.

For the initial analysis, level of empowerment, self-directed learning readiness and self-esteem were treated as dependent variables. Students in general scored fairly high levels of empowerment ($\bar{x} = 4$ on a 1-5 scale), self-directed learning readiness ($\bar{x} = 4$ on a 1-5 scale) with positive feelings about themselves (self-esteem, $\bar{x} = 3.3$ on a 1-4 scale).

**Comparison Between Types of Institutions**

Nursing students from both public and private institutions were included in the study in order to get a
representative sample. Mean scores for empowerment (VES), self-directed learning readiness (SDLRS) and self-esteem (SE) were compared in the preliminary analysis to determine whether these needed to be considered separately. Three one-way analyses of variance showed no significant difference between public and private institutions on VES \( (F = 1.00, \ p = 0.3) \), SDLRS \( (F = 0.80, \ p = 0.4) \) or SE \( (F = 0.6, \ p = 0.4) \) (see Table 4). Further analyses ignored type of institution and focused on the research questions of interest.

**Comparison Between Programs and Levels**

A two-way analysis of variance was used to determine if an interaction existed between levels and the program of study (see Table 5). Interactions were not significant for any of the variables \( (F = .38, \ p = .54 \text{ for VES}, \ F = .66, \ p = .42 \text{ for SDLRS}, \ F = 2.2, \ p = .14 \text{ for SE}) \). Neither were program main effects showing any significant difference between ADN and BSN students. There were significant differences between beginning and graduating students for both empowerment and self-directed learning readiness \( (F = 8.7, \ p < .01 \text{ for VES and } F = 14.6, \ p < .01 \text{ for SDLRS}) \). Self-esteem scores did not differ significantly.
Table 4

Mean Scores and ANOVA Results
Comparing the Types of Institutions

<table>
<thead>
<tr>
<th></th>
<th>Public n = 113</th>
<th>Private n = 181</th>
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<tr>
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<td>mean</td>
<td>sd</td>
<td>mean</td>
<td>sd</td>
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<tr>
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<td>4.06</td>
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<td>4.02</td>
<td>.34</td>
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<tr>
<td>SDLRS</td>
<td>3.98</td>
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<tr>
<td>SE</td>
<td>3.37</td>
<td>.44</td>
<td>3.33</td>
<td>.47</td>
</tr>
</tbody>
</table>

VES = Vincenz empowerment scale (1 = low to 5 = high empowerment)

SDLRS = Self-directed learning readiness scale (1 = low to 5 = high SDLR)

SE = Self-esteem scale (1 = low to 4 = high SE)
Table 5
Mean Scores and ANOVA Results Comparing Level and Program of Study

<table>
<thead>
<tr>
<th>BY LEVEL</th>
<th>Beginning $n = 145$</th>
<th>Graduating Students $n = 149$</th>
<th>F</th>
<th>p</th>
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<tbody>
<tr>
<td></td>
<td>$\bar{x}$</td>
<td>sd</td>
<td>$\bar{x}$</td>
<td>sd</td>
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<tr>
<td>VES</td>
<td>3.79</td>
<td>.35</td>
<td>4.10</td>
<td>.33</td>
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<tr>
<td>SDLRS</td>
<td>3.86</td>
<td>.40</td>
<td>4.05</td>
<td>.47</td>
</tr>
<tr>
<td>SE</td>
<td>3.3</td>
<td>.46</td>
<td>3.35</td>
<td>.45</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>BY PROGRAM</th>
<th>ADN $n = 171$</th>
<th>BSN $n = 123$</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>VES</td>
<td>4.03</td>
<td>4.04</td>
<td>.03</td>
<td>.85</td>
</tr>
<tr>
<td>SDLRS</td>
<td>3.96</td>
<td>3.95</td>
<td>.11</td>
<td>.74</td>
</tr>
<tr>
<td>SE</td>
<td>3.4</td>
<td>3.34</td>
<td>.12</td>
<td>.89</td>
</tr>
</tbody>
</table>

VES = Vincenz empowerment scale
SDLRS = Self-directed learning readiness scale
SE = Self-esteem scale
Empowerment has six subscales and they are potency (PS), independence (IS), relatedness (RS), motivation (MS), values (VS) and joy of life (JS). Mean scores for these subscales were plotted to compare between beginning and ending levels and ADN and BSN programs (see Figure 5-a and b). All scores were higher for graduating students as compared to beginners. Empowerment subscales were similar for both ADN and BSN students. They scored highest in motivation ($\bar{x} = 4.5$, $sd = .4$ for ADN and $\bar{x} = 4.5$, $sd = .4$ for BSN). They perceived themselves to have fairly strong life affirming values ($\bar{x} = 4.1$, $sd = .5$ and $\bar{x} = 4$, $sd = .4$) and felt involved with people ($\bar{x} = 4.1$, $sd = .5$, $\bar{x} = 4.1$, $sd = 4$). Their level of independence ($\bar{x} = 3.9$, $sd = .4$, $\bar{x} = 3.9$, $sd = .5$) and being in control and involved in making decisions ($\bar{x} = 3.7$, $sd = .5$, $\bar{x} = 3.9$, $sd = 4$) were slightly above average. Additionally, profiles of the six subscores comparing freshman and seniors from each program are presented in Figure 5 (c&d). Items showing the highest difference for beginners and graduating students of ADN programs were independence, motivation and joy of life, whereas greater increases for BSN students were potency and motivation.
Figure 5
Mean Scores of Empowerment Subscales

PS: POTENCY  MS: MOTIVATION
IS: INDEPENDENCE  VS: VALUES
RS: RELATEDNESS  JS: JOY OF LIFE
Dependent Variables and Participant Characteristics

One-way analyses of variance (ANOVA) were computed for empowerment (VES), self-directed learning readiness (SDLRS) and self-esteem (SE) by each of the demographic variables. F values and their significance are presented in Table 6.

Gender made no difference in VES, SDLRS or SE in this study. Similarly, racial/ethnic background and affiliation with a professional organization, in this study "Student Nurses Association" (SNA), did not show any relation to their level of empowerment, self-directed learning readiness or self-esteem.

Age of participants varied from 18 to 60. For analysis purposes, they were collapsed into three categories as: (a) 18 to 21, (b) 22 to 30 and (c) 31 and above. Analyses of variance was computed to determine if responses differed on VES, SDLRS and SE across groupings. Results showed a significant difference for empowerment ($F = 4.8$, $p < .01$). When followed up with a Tukey test, significant difference was seen between group one and the other two. Adult students were more empowered than those between 18-21 years of age. Self-directed learning readiness also differed significantly among age groups ($F = 19.7$, $p < .01$). Both groups above age 22 differed significantly from the younger group. Analysis of variance showed a significant difference in responses from the three age groups in their level of
Table 6
ANOVA Results of Empowerment, Self-Directed Learning Readiness, Self-Esteem by Demographic Variables

<table>
<thead>
<tr>
<th>Source</th>
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<th>SE</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>p</td>
<td>F</td>
</tr>
<tr>
<td>Gender</td>
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<td>.73</td>
<td>.05</td>
</tr>
<tr>
<td>Race</td>
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<td>Age</td>
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<td>Employment Status</td>
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<td>.74</td>
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<td>4.1</td>
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<tr>
<td>Community</td>
<td>7.28</td>
<td>&lt;.01</td>
<td>7.28</td>
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</table>
self-esteem ($F = 3.9, p < .02$). Again, group 1 and 2 contributed to the significant difference.

Educational preparation prior to entry into nursing varied from high school to post graduate work. Analysis of variance showed a significant difference for self-directed learning readiness ($F = 4.92, P < .01$) and self-esteem ($F = 5.68, P < .01$) but not for empowerment. Tukey test pointed to this difference as between high school graduates and baccalaureate prepared nursing students.

Present employment status did not affect their perception of empowerment, self-directed learning readiness or self-esteem. Those with previous work experience perceived themselves to have higher levels of self-directed learning readiness ($F = 4.1, p < .05$). This was not influenced by the nature of the work setting. The years of work experience was not associated with their perception of empowerment or self-esteem. It is unclear whether this is related to their work experience in the health field as many have indicated. The only professional affiliation stated in their responses was "Student Nurses' Association" (SNA). Even through affiliation with SNA had no influence on any of the three dependent variables, those participating in community organizations showed higher levels in their responses in empowerment ($F = 7.28, p < .01$) and
self-directed learning readiness \( (F = 7.28, p < .01) \) and self-esteem \( (F = 3.60, p = .05) \) from those who did not.

**Relationship among Variables**

Correlations were computed to examine the bivariate relationship between variables (see Table 7). Levels of empowerment were moderately related to SDLRS \( (r = .61) \) and SE \( (r = .57) \) and the latter two were mildly related to each other \( (r = .33) \). Empowerment was mildly correlated with age and level in the program as well. Similar relationship was also seen with self-directed learning readiness.

**Predictors of Empowerment**

In order to determine which variable in the study is the best predictor of empowerment, a step-wise regression analysis was done (see Table 8). The first variable that entered the equation was self-directed learning readiness which explained 42\% of the variance in empowerment. Self-esteem entered the equation second and added another 18\%. Other variables failed to have any additional explanatory power.

**Summary**

Statistical and descriptive findings were presented in this chapter. Nursing students in this study with higher levels of self-directed learning readiness were more likely to be graduating nursing students, to be over 22 years of
age, to have worked longer and achieved a higher educational level prior to entering a nursing program and to be more active in community organizations than those with lower levels of self-directed learning readiness.

Nursing students in this study with higher levels of self-esteem were more likely to have achieved a higher educational level prior to entering a nursing program, to be between 22-30 years of age, and active in community organizations than those with lower levels of self-esteem.

Nursing students in this study with higher levels of empowerment were more likely to be graduating nursing students, to be more self-directed learners, to be more active in community organizations, to have higher self-esteem than those with lower levels of empowerment.

In addition, the level of self-directed learning readiness and self-esteem of nursing students in this study were the best predictors of their empowerment.

The type of nursing programs in which nursing students in this study were enrolled was not found to be related to their level of self-directed learning readiness, self-esteem or sense of empowerment.
Table 7
Relationship Between Variables

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<th></th>
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<th>SE</th>
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<th>Level</th>
<th>Age</th>
<th>Gender</th>
<th>Work Exp.</th>
</tr>
</thead>
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<td>.57**</td>
<td>.03</td>
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<td></td>
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</tr>
<tr>
<td>Gender</td>
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</tr>
<tr>
<td>Work</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.00</td>
</tr>
<tr>
<td>Exp.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

* = p < .05, ** = p < .01 (2 tailed)

VES = Vincenz empowerment scale
SDLRS = Self-directed learning readiness scale
SE = Self-esteem scale

Program = Program of study (coded as ADN-0, BSN-1)
Level = Level in the program (coded as beginners-0, graduating students-1)
Age = Age of participants (Range 18-60)
Gender = (coded as female-0, male-1)
Work = Years of work experience prior to entering nursing
<table>
<thead>
<tr>
<th>Step Number</th>
<th>Variable</th>
<th>$R^2$</th>
<th>$\Delta R^2$</th>
<th>$p$</th>
<th>$\beta$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SDLRS</td>
<td>0.42</td>
<td>0.42</td>
<td>&lt;.01</td>
<td>0.50</td>
</tr>
<tr>
<td>2</td>
<td>SE</td>
<td>0.60</td>
<td>0.18</td>
<td>&lt;.01</td>
<td>0.44</td>
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SDLRS = Self-Directed Learning Readiness Scale
SE = Self-Esteem
CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

The health care system in the 1990s is characterized by unrelenting change, increasing complexity and high costs. Nursing as a profession is growing ever more complex within this rapidly developing health field. One of the major problems experienced by the nursing profession is the shortage of qualified nurses. This problem is intensified by the frustration and disillusionment experienced by the new entrants into the work force and the low morale, high attrition rate, and rapid staff turnover, or stagnation in their competence as they continue in their practice. One issue that is consistently identified as a barrier to continued learning and commitment to quality service is the powerlessness experienced by the nurses (Ashley, 1975; Bush, 1988; Brown & Stewart, 1987; Corwin, 1961; Ellis & Harley, 1984; Gorman & Clark, 1986; Kramer, 1974; Muff, 1982; Murray, 1983; Prescott & Dennis, 1985; Robinson, 1991; Sohier, 1992). Therefore, the onus for nursing education is to produce empowered professionals who have the resources and commitment to persist and influence change if needed to provide quality service and control costs.

The literature review revealed a few studies pointing out positive effects of empowerment among staff nurses, but
no study was found that addressed empowerment of nursing students in their basic nursing educational program; a vital period in which they are socialized into the profession.

The purpose of this study was to determine the level of empowerment among nursing students of two types of basic nursing educational programs and the relationship of empowerment to selected variables. Those selected variables were self-directed learning readiness, self-esteem, and demographic information such as age, gender, ethnic and educational background, work experience, present work status, affiliation with professional and community organizations, and the level and type of program of study. The research questions were:

1. Does the level of empowerment, self-directed learning readiness and self-esteem differ for:
   a. students entering basic educational programs and for those ready to graduate?
   b. students in associate and baccalaureate degree programs?

2. How is the level of empowerment associated with self-directed learning readiness, self-esteem, nursing educational programs and selected demographic variables.

   This was a descriptive exploratory study in which the data were collected by means of survey questionnaires. The instruments used were: (a) Vincenz Empowerment Scale, (b)
Self-Directed Learning Readiness Scale, (c) Self-Esteem Scale, and (d) Demographic Data Sheet. The settings for this study were five schools of nursing in the mid-Atlantic area, representing both private and public institutions. The total population of this convenience sample, freshmen and graduating classes of associate and baccalaureate degree programs, were included in the study. Of the 323 questionnaires distributed, 294 were returned for a response rate of 91%.

The statistical package, SPSS, was used to analyze the data. Frequency distributions, descriptive statistics, analysis of variance, correlations, and regression procedures were employed to analyze the data.

For the initial analysis, level of empowerment, self-directed learning readiness and self-esteem were treated as dependent variables. Students in general perceived themselves to have fairly high levels of empowerment ($M = 4$ on a 1-5 scale), self-directed learning readiness ($M = 4$ on a 1-5 scale) and felt positive about themselves ($M = 3.3$ on a 1-4 scale). Vincenz (1990) compared the levels of empowerment among clients, community residents and school board members. Total scores of empowerment was reported as 261 ($sd = 38$), 293 ($sd = 30$) and 312 ($sd = 26$), respectively, for the above groups. Empowerment levels of students in this study group were 293 ($sd = 28$) for freshman
students and 303 (sd = 24) for graduating seniors. Clark's (1991) study found community health nurses to be more empowered than hospital nurses and that was reported as 301. This study sample was more empowered than the staff nurses in the hospital setting as well as the community health field. Yet, far more is desired for a profession as nursing, with its perpetual problem of powerlessness. Analysis of variance revealed no differences between groups based on the type of institution, program, or gender. Graduating seniors perceived to have higher levels of empowerment and self-directed learning readiness when compared with freshman students, which indicates a possible positive influence from their educational process. When mean scores of empowerment subscales were compared, seniors scored higher in all six subscales.

Demographic characteristics of participants revealed this sample of nursing students to be heterogenous. Nursing students in this sample ranged in age from 18 to 60 with an average age of 27.7 (sd = 7.6). Seventy-five percent of the participants were over 22 years of age. The literature revealed a national trend toward increased number of nontraditional students. Adult students in this study sample were more empowered than those between the ages of 18-21. Young adults in the age range of 22 to 30 emerged as those with the highest level of empowerment. Both
self-directed learning readiness and self-esteem levels also were highest for this group.

Twelve percent of the study sample (n = 35) were men, which is higher than the national estimate of 2% for nursing. However, they did not differ in their level of empowerment, self-directed learning readiness or self-esteem. Similarly, this study sample did not differ in any of the three dependent variables in spite of the diverse ethnic representation. Education of the participants prior to the entry into nursing varied from high school to graduate degrees. High school graduates represented only 19% of the associate degree programs, but constituted 50% of the baccalaureate group. Educational level correlated positively with both self-directed learning readiness and self-esteem, but not empowerment. Ninety-four percent of the study group had prior work experience and about half of them were continuing to work at least part-time. Prior work experience correlated positively with self-esteem and self-directed learning readiness.

About 25% of the sample were members of the Student Nurses' Association and about the same number were involved in community organizations. Involvement in professional organizations such as SNA showed no relationship to their self-esteem, self-directed learning readiness or empowerment. Those students involved in community
organizations had higher levels of empowerment, self-directed learning readiness and self-esteem as compared to those not involved. Stepwise regression analysis indicated self-directed learning readiness as the best predictor of empowerment contributing to 42% of its variance. Self-esteem contributed an additional 17% of the variance with a total influence of 59%.

Conclusions

Nursing students in this study were a diverse group of people, predominantly women, with varying age and educational levels. Many of them selected nursing as a second career. This is in line with the national trend in student enrollment in nursing.

It can be concluded that the nursing students who participated in this study perceived themselves to be empowered individuals which is contrary to earlier literature available on the topic (Kramer, 1974, 1975; Prescott & Dennis, 1985; Roberts, 1983; Smith, et al., 1982). It is also reassuring that the graduating students in this study experienced higher levels of empowerment than did the entering freshmen. This is consistent with the study findings of Gorman and Clark (1986) that it is possible to enhance the level of empowerment through planned strategies. The fact that graduating students had
significantly higher levels of empowerment in comparison to freshman students, it may be possible that certain practices in schools of nursing is facilitating the empowerment process. This concurs with the expectations of faculty as shown by Carlson-Catalano (1988). The level of empowerment correlated highly with self-directed learning readiness and self-esteem supports the social learning theory and findings of Zimmerman (1992).

Fairly high levels of perceived self-directed learning readiness were present among nursing students in this study which contradicts the finding of Millonig (1985). It is possible that this group of nursing students are more highly motivated than their predecessors. There was an increase in the perceived level of self-directed learning readiness for graduating students when compared to freshman students. This concurs with findings of Brockett (1985-b), and Sabbaghian (1979). Age and educational level prior to entry into nursing also were correlated with their level of self-directedness. This study did not support McClosky's (1990) finding that nurses have low autonomy and were less satisfied.

Self-esteem levels were in the high range for this study sample. Those with higher levels of education experienced greater self-esteem. Only a minimal level of increase in self-esteem was observed among the graduating
students. This study did not support the premise that BSN programs, or instructional experience in private institutions may lead to greater self-directed learning, self-esteem or empowerment.

This study did not support the earlier findings suggesting that male members of nursing profession experience greater empowerment (Ellis & Hartley, 1984; Kanter, 1977; Prescott & Dennis, 1985). Even though men were a minority in this study group as expected, there were no differences in their level of empowerment, self-directed learning readiness or self-esteem when compared to female students. While some studies found relationship between racial/ethnic background and empowerment (Cummins, 1986; Davis, 1988; Munro, 1980; Zimmerman, 1992), this was not the case here. In addition, there was no evidence to support the findings of Munro (1980) and Linares (1988) that ethnicity was closely related to their self-directed learning readiness or loss of control. In this study, ethnicity was not related to empowerment, self-directed learning readiness or self-esteem.

Prior education of nursing students in this study varied from high school to graduate degrees as expected according to the present trend (Gruca, 1994). No relationship was observed in this study between education and empowerment. However, self-directed learning readiness
increased with educational level which was consistent with previous studies (Echols, Armstrong, & Rustia, 1992; Linares, 1988; Sabbaghian, 1979). Similarly, self-esteem levels also increased with educational accomplishments, supporting the findings of Muff (1982) and Johnson (1989).

Membership in professional organizations was evident for 25% of this study group. Hawkins (1992) recommends professional affiliation as a source for empowering students. This study did not show any evidence of relationships between empowerment and membership in student nurses' association. It is unclear how active they were in the organization. Involvement in community organizations correlated positively with the students' level of empowerment which supports the findings of Zimmerman (1992) and Kieffer (1984).

Recommendations for Future Research

While findings from this study have provided support for certain aspects of previous research, they have also raised questions for further research.

This study attempted a cross sectional view of students' empowerment, its antecedents and moderators. A longitudinal study would provide greater insight into actual growth in their level of empowerment as they move through their nursing program. An experimental study utilizing
measures to enhance the levels of empowerment among nursing students will provide valuable information for nurse educators and continuing education providers.

It may be anticipated that with longer duration of study, more liberal arts and science courses and socialization to professional roles in BSN programs would lead to a greater increase in self-directed learning readiness, self-esteem and empowerment than ADN programs. The age level of ADN students and their prior education and work experience may have overshadowed the anticipated effect of BSN programs in this study. At present, BSN graduates are considered professional nurses with higher levels of competence. Therefore, further research is needed in which age, education and work experience are controlled.

It is anticipated that graduating students with higher levels of self-directed learning readiness and empowerment may continue to learn and reach their full potential. The graduating students had significantly higher levels of empowerment and self-directed learning readiness than freshman students. Further study is needed to examine specific teaching-learning strategies which are most predictive of improving in self-directed learning readiness and empowerment.

The level of self-esteem was identified as a major predictor of empowerment. The degree of change in the level
of self-esteem in this study population was inconclusive. Further study is needed to identify the impact of nursing education on students' level of self-esteem.

Many conceptual models have been proposed to empower nursing students, but very few research studies in this area have been undertaken to find empirical evidence. Therefore, studies are needed to advance the knowledge of empowerment.

Increasing numbers of nontraditional, adult students in nursing programs calls for greater utilization of adult learning principles in the educational process. How familiar are nursing faculty with adult learning principles as they are dealing with more and more adult students needs to be studied. In addition, how empowered are they to empower their students and clients? These are questions that require further research.

Implication for Education

Findings from this study have implications for both education of nursing students as well as continuing education of practicing nurses. Without jeopardizing exactitude, which often is the reasoning for reluctance to change, educators could adopt teaching-learning strategies to inculcate in students a sense of pride in self and in a profession they both have chosen to embrace. Period of professional preparation would also be a good practicing
ground to master self-directedness in learning if they haven't already. The diverse student population as seen in this study sample also possess immense resources that should be recognized. Nursing faculty could adopt adult learning principles in their teaching-learning transactions. Students should be encouraged in independent decision making and autonomy in their choices.

Learning from role models is an empowering factor according to social learning theory. Nurse educators should be viewed as role models both in their professional expertise and their interactions with people.
REFERENCES


APPENDIX A

VINCENZ EMPOWERMENT SCALE
APPENDIX A

VINCENZ EMPOWERMENT SCALE

Sample questions from the Copyrighted Instrument.

<table>
<thead>
<tr>
<th></th>
<th>Almost always untrue</th>
<th>Often untrue</th>
<th>Don't Know</th>
<th>Often true</th>
<th>Almost always true</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I wish I had more courage.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. When people band together, they can move mountains.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. I remember the teachers in my life with appreciation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I seem to have a lot of bad luck.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

For further information, contact:

Dr. Lilli M. Vincenz
1909 North Ohio Street
Arlington, Virginia 22205
(Tel: 703-523-2731)
APPENDIX B

SELF-DIRECTED LEARNING READINESS SCALE
## APPENDIX B

### SELF-DIRECTED LEARNING READINESS SCALE

Sample questions from a Copyrighted Instrument.

<table>
<thead>
<tr>
<th>ITEMS:</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Almost never true of me; I hardly ever feel this way</td>
</tr>
<tr>
<td></td>
<td>Not often true of me; I feel this way less than half the time</td>
</tr>
<tr>
<td></td>
<td>Sometimes true of me; I feel this way about half of the time</td>
</tr>
<tr>
<td></td>
<td>Usually true of me; I feel this way more than half the time</td>
</tr>
<tr>
<td></td>
<td>Almost always true of me; there are very few times when I don't feel this way</td>
</tr>
<tr>
<td>1. I'm looking forward to learning as long as I'm living.</td>
<td>1</td>
</tr>
<tr>
<td>2. I know what I want to learn.</td>
<td>1</td>
</tr>
<tr>
<td>3. When I see something that I don't understand, I stay away from it.</td>
<td>1</td>
</tr>
<tr>
<td>4. If there is something I want to learn, I can figure out a way to</td>
<td>1</td>
</tr>
</tbody>
</table>

For further information, contact:

Dr. Lucy M. Guglielmino  
734 Marble Way  
Boca Raton, Florida 33432  
(Tel: 305-392-0379)
APPENDIX C

SELF ESTEEM SCALE*
APPENDIX C

SELF ESTEEM SCALE*

Please record the appropriate answer per item depending on whether you strongly agree, agree, disagree or strongly disagree with it.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. On the whole I am satisfied with myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. At times I think I am no good at all.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. I feel that I have a number of good qualities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. I am able to do things as well as most other people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. I feel I do not have much to be proud of.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. I certainly feel useless at times.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. I feel that I am a person of worth, at least on an equal plane with others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. I wish I could have more respect for myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. All in all, I am inclined to feel that I am a failure.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. I take a positive attitude toward myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
APPENDIX D

DEMOGRAPHIC INFORMATION
APPENDIX D

DEMOGRAPHIC INFORMATION

Your response to these general questions will help in interpreting the results of the study. This information will not be used to identify you and will be kept strictly confidential.

(1) What was your age on your last birthday? __________

(2) Circle your gender. 1. Female 2. Male

(3) Which of the following best describes your racial or ethnic identification? (Circle number)

1. African-American/Non-Hispanic
2. African-American/Hispanic
3. American Indian
5. Hispanic
6. White--Non-Hispanic
7. Other (Please specify) ________________________

(4) What is your current education program? (Circle one)

1. Associate 2. Baccalaureate Degree

(5) What is your current level in the program? (Circle one)

1. Freshman 2. Senior

(6) Prior to entry into this nursing program, what was the highest level of education that you had completed? (Circle one)

1. High School Diploma
2. Some College
3. Bachelor's Degree
4. Master's Degree
5. Other (Please specify) ______________________
(7) What is your employment status at present? (Circle one)

1. Employed, full time
2. Employed, part time
3. Not employed

(8) What type of work experience have you had? (Check all that apply) (No. of years)

1. In a hospital
2. Health service outside a hospital
3. Other

(8) Are you affiliated with any professional/community organization? (Check all that apply)

1. Student Nurses' Association
2. Other (Specify) ____________________________
APPENDIX E

SAMPLE LETTER TO DEANS
From
Rajamma V. George  
2877 Glenvale Dr.  
Fairfax, VA 22031  
Tel. (703)280-2925 or (703)284-1588

To
The Dean of Research  
School of Nursing

Dear Dr. Smith,

I am a nursing instructor currently enrolled in a doctoral program in Adult and Continuing Education at Virginia Polytechnic and State University. My research interests are in empowerment and self-directed life-long learning. For my dissertation I wish to study the level of empowerment of graduating nursing students and its relationship to self-directed learning readiness, self-esteem, and selected demographic variables.

I would like to include some of the nursing students at your school in my research sample. The study will involve the use of survey techniques and the students participation would be entirely voluntary. Four instruments will be used in this study and they are: Vincent's empowerment scale (1990), Self-directed learning readiness scale (Guglielmino, 1977), Rosenberg's self-esteem inventory, and the demographics. I am enclosing a brief description of the study and sample copies of all four questionnaires for your review. Information provided through the study will be presented as group trends, and individuals or agency will not be identified. The student's name will not appear on the questionnaires.

I will be calling you within the next seven days to answer any questions you may have. I look forward to a favorable reply.

Thanking you,

Sincerely,

Rajamma V. George  
April 28, 1994
APPENDIX F

COVER LETTER TO STUDENTS
Dear Nursing Student:

Thank you very much for agreeing to take part in this research study. This study is designed to develop a beginning understanding of the feeling about life and the learning among students. I believe that the information gained from this study will provide useful data for nursing educators, administrators, and continuing education providers to better meet the needs of students and nurses. I anticipate that this questionnaire will take you approximately 20 to 30 minutes to complete.

There are three points that I would like to emphasize:

1. Your participation is entirely voluntary. There is no penalty for not participating, and you may withdraw from the study at any time for any reason.
2. Your responses are completely anonymous. Please do not put your name or social security number anywhere on this survey. The results will describe group trends rather than individual responses.
3. You have to be 18 years of age or older to participate.

To clarify the instructions, they are as follows:

Please read the questions as well as the responses very carefully and mark the number of the response which best expresses your feeling.

There are no right or wrong answers. It is not necessary to spend a very long time on any question. Mark your answer quickly and go on to the next item.

It is important that you complete all the items on each of the pages.

Again, thank you very much for taking part in this study. If you have any questions about this study or would like to know the results, please feel free to contact me at (703) 280-2925.

Sincerely,
Rajamma George
APPENDIX G

INFORMED CONSENT FORM
APPENDIX G

Statement of Informed Consent

I understand that the purpose of this study is to develop a beginning understanding of the students' feeling about life and learning as they are socialized into the nursing profession. I further understand that this study is being conducted by Rajamma George as part of her doctoral dissertation under the supervision of Dr. Harold Stubblefield of Virginia Polytechnic Institute and State University in Falls Church, Virginia.

I have read the instructions for completing the questionnaires and understand the conditions for my participation in this study.

I understand that my response will be completely anonymous and the results will describe group trends rather than individual responses.

I understand that my participation is entirely voluntary, that there is no penalty for my refusing to participate, and that I may terminate my participation at any time and for any reason.

I understand that there is no cost to me for participating in this study.

I understand that I have the option not to answer any question that makes me uncomfortable. Further, if I have any questions, I can talk with Rajamma George privately either directly or by phone. She can be reached by phone at (703) 280-2925.

I have read this form, understand my rights and my role with regards to this research, and agree to participate.

_________________________________________  ______________
Participant's Signature                     Date
VITA
Rajamma Varghese George

Degrees Conferred:

1994        Virginia Polytechnic Institute and State University
            Blacksburg, Virginia
            EdD
            Adult and Continuing Education

1971        Delhi University
            India
            MN, Medical–Surgical Nursing
            Nursing Education

1962        College of Nursing
            Christian Medical College & Hospital
            Vellore, India
            (Madras University)
            BSN
            Nursing

Other Education:

1963        College of Nursing
            Christian Medical College & Hospital
            Vellore, India
            Diploma
            Nurse–Midwife

Professional Experience:

1976–1994    Marymount University
            Arlington, Virginia
            Assistant–professor
            of Nursing (Tenured)

1980–1985    Doctor's Hospital
            Arlington, Virginia
            Critical Care Nurse
            (Part Time)

1975–1976    Doctor's Hospital
            Washington, DC
            Critical Care Nurse

1973–1974    All India Institute of Medical Sciences
            New Delhi, India
            Nursing Instructor
            Post RN–BSN Program

1972        World Health Organization
            SE Asia–Region
            (Posted to Ceylon)
            Short-term Consultant

1971–1972    National Institute of Health
            Administration and Education
            New Delhi, India
            Research Officer
            (Activity Study of Nurses)

1966–1969    Arabian American Oil Company
            Saudi Arabia
            Industrial Health Nurse

1963–1966    College of Nursing
            Christian Medical College and Hospital
            Vellon, India
            Nursing Instructor